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EXECUTIVE SUMMARY

Georgia is a large and rapidly growing state with a very diverse population. While Georgia is among the larger states by population and landmass, it is also among the poorer states in terms of median household income and percent of poverty level. For this reason, many individuals with serious mental illness (SMI) or serious emotional disturbance (SED) rely on publicly funded services to meet their needs. Sixty-nine percent of the persons living in Georgia reside in metropolitan areas that comprise only 23% of the state's land area. The remaining 77% of the state is very rural and populated by only 31% of the total state residents. The large distances that are involved in getting to service sites complicate Service access for individuals in rural areas. In the Adult and Child and Adolescent plans an indicator has been chosen that examines out-of-clinic service delivery for persons in rural areas.

The Division of Mental Health, Developmental Disabilities and Addictive Disease (DMHDDAD) and the Department of Human Resources (DHR) each experienced change in leadership during state fiscal year 2004, following several months of interim leadership for both. Because both the DHR Commissioner and the DMHDDAD Director came to their new roles within the past three months, it is difficult to predict what changes will come that will impact the state mental health system. The state has faced significant revenue shortfalls in recent years, necessitating budget cuts that have been difficult to absorb. The DMHDDAD leadership will be examining programs and services to determine priorities and the most effective use of available resources.

The change in DMHDDAD governance that was implemented in FY 2003 reduced the number of regions from thirteen to seven, to correspond with the areas served by the seven state psychiatric hospitals. This change facilitated the inclusion of both hospital and community service management under the same regional authority. With this change, consumers are experiencing more seamless services as they move from inpatient to community services. The regional planning boards created by this legislation are still required by law to have a minimum of 50% of the membership comprised of consumers and family members. While the boards no longer have responsibility for governance, each board has the responsibility for service system planning and needs assessment. The regional office assumes the responsibility for resource allocation, contracting for services, monitoring of services, consumer protection and consumer/family satisfaction. While FY 2005 contracts for services continue to be performance based, requiring providers to meet identified consumer outcomes in order to receive full payment, planning is underway to adopt a "fee-for-service" program, perhaps as early as mid-year. Such a change will lead to contract changes for all provider agencies.

The overarching philosophy and vision of the mental health system in Georgia are focused on the concepts of Hope, Recovery and Resiliency for adults with SMI and for children and adolescents with SED who receive services. These concepts are carried out in the system through the requirement of consumer and family involvement on regional planning boards. Hope, Recovery and Resiliency are embraced in the movement to more consumer and family directed and/or operated services. The messages are further articulated in training events designed to help

provider staff understand the difference between managing symptoms and helping consumers understand their illnesses and become full partners in their treatment.

The DMHDDAD feels that it is critical to build a comprehensive mental health system based on promoting resiliency for youth with SED and their families. Historically, traditional public sector mental health services have fallen short of meeting the needs of high-risk children and families and have failed to promote resiliency factors that are needed. The DMHDDAD is committed to expanding a full array of services that promote resiliency in youth and families and to build on natural supports systems. Prevention, early intervention and treatment services provide youth and families opportunities to gain protective factors and skills needed to build resiliency. The DMHDDAD plans to continue expanding services into the community according to a wraparound philosophy, as opposed to the traditional clinic setting, to promote resiliency between child and adolescent consumers and their families.

One of the primary values guiding the mental health service system in Georgia is consumer choice, leading regional offices to employ creative strategies of provider recruitment and development. Many of the services contracted by regional offices are delivered by public agencies known as Community Service Boards (CSBs). In all, there are 25 CSBs with responsibility for service delivery throughout the state. Regions also contract with numerous private providers to expand the choices available to consumers and their family members. As a result of a change in the state Medicaid Plan, shifting from a Clinic Option to a Rehabilitation Option, more providers are now eligible to bill Medicaid for service delivery. This has and will continue to lead to greater expansion of service providers from which consumers can choose.

A second value of Georgia's mental health system is that services should be provided in community settings that encourage the development of natural supports and enable consumers to be contributing members of their communities. In support of this value, Georgia has focused significant efforts during the past ten years on reducing reliance on inpatient hospitalization and redirecting unused hospital resources to fund community services. The seven state psychiatric hospitals that are part of the DMHDDAD system continue to provide inpatient treatment for individuals experiencing acute episodes of illness requiring hospitalization. Numbers of admissions for inpatient treatment have been dramatically reduced due to the increase in community services. With the changes to the system that brought hospital and community services under the same structure, continuity of care between hospital and community services is improving.

Much attention has been directed at measuring service effectiveness and consumer outcomes, with continuing focus on evidence based best practice service availability. Goals in both the State Plan for adults with SMI and youth with SED and their families relate to availability of "Best Practice" services, numbers of individuals served in those services, and improved consumer functioning as a result of those services.

Adult consumers with SMI have consistently repeated the message that employment and self-help services are priorities for a quality mental health system. In response to these priorities, many of the goals and indicators of the adult plan focus on employment and on development of trained and certified consumer staff for consumer directed services. The adult plan also includes

goals addressing service needs of individuals who are homeless and those who are involved with the criminal justice system.

Funding allocations for community services for children and adolescents with SED has expanded from under one million dollars in the late eighties to approximately \$45 million dollars today. This has occurred as a result of new state funding, redirection of funding from hospital services and increases of mental health block grant funds. Child and adolescent inpatient bed capacity has been reduced to one-third of the capacity in the late eighties and funding realized from this savings provided to support community services enhancements. Additionally, the state targeted the major portions of Mental Health Block Grant increases for expansion of community services for youth with SED. During tight state budget years in FY2002 and 2003 new state appropriations were approved by the General Assembly to develop additional C&A community crisis services and Intensive Family Intervention services across the state. Fiscal year 2004 was the first state fiscal year since FY 1989 that no additional funding was appropriated for service expansions. DMHDDAD is committed to continue needed service expansions for youth with SED and their families and will continue to explore opportunities for financing new services.

Families and advocates for children have for many years indicated that their first priority for the C&A mental health system is integrated, community based services to enable youth with SED to be served in their homes and in their communities. Toward this end, DMHDDAD has launched a Quality Improvement Initiative on Building Systems of Care that has included broad stakeholder input on development of Regional strategic action plans. In addition, DMHDDAD and its Regional MHDDAD Offices have partnered with local initiatives focused on improving integrated service delivery to youth and their families.

The mental health system in Georgia is dynamic and is continually seeking to improve the quality of services provided to Georgia citizens. Much of the progress in the system is attributed to the strong involvement of consumers and families in planning and development of services. Georgia is proud of its position as a national leader in consumer and family empowerment and partnership.

PART B.

Administrative Requirements, Fiscal Planning Assumptions and Special Guidance

I. Federal Funding Agreements, Certifications and Assurances

- (1) **Funding Agreements:** included as Appendix A
- (2) **Certifications – PHS 5161-1:** included as Appendix B
- (3) **Lobbying and Disclosure:** included as Appendix C
- (4) **Assurances – Non-Construction Programs:** included as Appendix D
- (5) **Public Comment on the State Plan:** Georgia posts the state plan on the DHR web site to invite public comment prior to submission of the Mental Health Block Grant application. In addition, each regional office receives a copy of the state plan to make it available to members of the regional planning boards. Each year, during the week prior to the convening of the Georgia General Assembly, another public comment opportunity is provided during public budget hearings. Comments are recorded and provided to DMHDDAD leadership.

II. Set-Aside for Children's Mental Health Services Report

Data Reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Calculated FY 1994

Actual FY 2003

Actual/**Estimate** FY 2004

\$4,627,456

\$40,226,742

\$38,926,283

III. Maintenance of Effort Report

MOE information reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Actual FY 2002

Actual FY 2003

Actual/**Estimate** 2004

\$136,120,029

\$136,081,492

\$136,101,655

IV. State Mental Health Planning Council

- (1) **Membership Requirements** The Georgia Mental Health Planning and Advisory Council (MHPAC) membership conforms to the membership requirements as defined in Section 1914© of the PHS Act. Membership requirements, recruitment and terms are defined in the MHPAC Bylaws, which follow Tables 1 and 2 in this document.

(2) State Mental Health Planning Council Membership List and Composition
Tables 1 and 2

Table 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization	Address, Phone, Fax
Angela Barnett	Regional Representative for C&A MH	West Central MHDDAD Region/ Henry County Juvenile Court	34 John Frank Ward Boulevard McDonough, GA 30253 PH: (770) 898-7642 FAX: None
Linda Buckner	Adult Consumer		133 Carnegie Way, Suite 310 Atlanta, GA 30303 PH: (404) 523-7093 FAX: None
Alan Burden	Regional Representative for AMH	Central Region MHDDAD Planning Board	152 Carter Circle Warner Robins, GA 31093 PH: (478) 923-6472 FAX: None
Carol Bush	State Employee-Member-At-Large	Georgia Regional Hospital at Atlanta	3073 Panthersville Road Decatur, GA 30034 PH: (404) 243-2160 FAX: None
Maya Carter	State Employee-Medicaid Agency Representative	GA Department of Community Health	Division of Medical Assistance 2 Peachtree St., NW, 37 th Floor Atlanta, GA 30303 PH: (404) 657-5466 FAX: (404) 657-8366
David Cowan	Representative of Deaf/Hard of Hearing Community	GA Interpreting Network Services	4376 Marjorie Road Snellville, GA 30039 PH: (404) 521-9100 FAX: (404) 521-9121
Jan Cribbs	State Employee-Rehabilitation Services Rep.	GA Department of Labor	Division of Rehabilitation Services 1700 Century Circle Atlanta, GA 30345-3020 PH: (404) 235-0156 FAX: (404) 468-0197
Larry Fricks	State Employee-Adult Consumer/ Director GA Office of Consumer Relations	GA DMHDDAD	Office of Consumer Relations Division of MHDDAD 2 Peachtree St., NW, 23 rd Floor Atlanta, GA 30303-3171 PH: (404) 657-2100 FAX: (404) 657-2187
Maggie Gilead, Ph.D.	Regional Representative for AMH	Metro Region MHDDAD Planning Board	3325 Idlecreek Way Decatur, GA 30034 PH: (404) 727-6937 FAX: (404) 727-8514
Allan Goldman	State Employee-Aging Services Agency Rep.	Division of Aging	Department of Human Resources 2 Peachtree Street, NW, 36 th Floor Atlanta, GA 30030 PH: (404) 657-5255 FAX: (404) 657-5285

Gregg Graham	Adult/C&A Service Provider	Behavioral Health Link	961 Broad Street Augusta, GA 30901 PH: (706) 722-2353 ext. 342 FAX: (706) 722-6963
Cathy Griffin	State Employee Regional Rep. for C&A MH	Metro MHDDAD Regional Office	100 Crescent Centre Pkwy, Suite 900 Tucker, GA 30084 PH: (404) 463-6367 FAX: (404) 463-6369
Amy Hale	State Employee- Social Services Agency Rep	Division of Family and Children Services	Department of Human Resources 2 Peachtree St, NW, 22 nd Floor Atlanta, GA 30303-3171 PH: (404) 65703575 FAX:
Phylis Holiday	Adult Service Provider/Regional Rep. for AMH	East Central MHDDAD Region Planning Board/ Mental Health Association of Greater Augusta	1720 Central Avenue Augusta, GA 30904 PH: (706) 736-6857 FAX: (706) 738-3548
Gwendolyn Skinner	State Employee- State Mental Health Agency Director	Division of MHDDAD	Department of Human Resources 2 Peachtree St, NW, 22 nd Floor Atlanta, GA 30303-3171 PH: (404) 657-2260 FAX: (404) 657-1137
Ronnie Jackson	C&A Consumer	Georgia Parent Support Network, Inc.	1381 Metropolitan Parkway Atlanta, GA 30310 PH: 404/758-4500 FAX: None
Ellyn Jeager	Adult Consumer	National Mental Health Association of GA	100 Edgewood Ave., #502 Atlanta, GA 30303 PH: (404) 527-7175 FAX: (404) 527-7187
Cheryl Josephson	Adult Consumer	Jansen Pharmaceutical	2752 Cravey Drive Atlanta, GA 30345 PH: (770) 493-1862 FAX: None
William Kissell	State Employee- Criminal Justice Agency Rep.	GA Department of Corrections	Floyd Building, 9 th Floor East Tower 2 MLK, Jr. Drive, SE Atlanta, GA 30334 PH: (404) 657-8237 FAX: (404) 651-6414
Ron Koon, Ph.D.	State Employee- Juvenile Justice Agency Rep	GA Department of Juvenile Justice	2 Peachtree St, NW, 4 th Floor Atlanta, GA 30303 PH: (678) 458-6487 FAX: (770) 381-7486
Dave Lushbaugh	Family Member of Adult Consumer	NAMI GA	3050 Presidential Dr., Suite 202 Atlanta, GA 30340 PH: (770) 234-0855 FAX: (770) 234-0237
Pierluigi Mancini	Adult Service Provider	Clinic for Education, Treatment and Prevention of Addiction	7740 Roswell Road, Suite 700 Atlanta, GA 30350 PH: (770) 452-8630 FAX: (770) 442-1189

Goldie Marks	Adult Consumer/ AMH Regional Representative	North Regional MHDDAD Planning Board	804 West Doyle Street Toccoa, GA 30577 PH: (706) 452-8630 FAX:
Gail Mattox, MD	C&A Psychiatrist in private practice (Not a provider in public system)	Morehouse School of Medicine	Department of Psychiatry and Behavioral Sciences 720 Westview Dr., SW Atlanta, GA 30310 PH: (404) 756-1440 FAX: None
Anna McLaughlin	C&A Service Provider	Georgia Parent Support Network, Inc.	1381 Metropolitan Parkway Atlanta, GA 30310 PH: 404/758-4500 FAX: None
Sandra Mullins	Representative of Refugee Community	Refugee Resettlement & Immigration Services of Atlanta	4151 Memorial Dr, Suite 205-D Decatur, GA 30032 PH: (404) 622-2235 ext. 227 FAX: (404) 622-3321
Don Novak	Family Member of Adult Consumer /Regional Rep for AMH	Southeast MHDDAD Regional Planning Board	383 Pyles Marsh Road Brunswick, GA 31525 PH: (912) 466-0329 FAX: None
Lisa Pace	Family Member of C&A Consumer	Georgia Parent Support Network, Inc.	1631 Quail Run Conyers, GA 30094 PH: (770) 922-4598 FAX: None
Susan Pajari	Representative of Prevention Association	Member-At-Large	125 Tara Blvd. Loganville, GA 30052 PH: (770) 554-4775 FAX: None
Ernestine Pittman	State Employee- Regional Coordinator	Metro MHDDAD Regional Office	100 Crescent Centre Pkwy, Suite 900 Tucker, GA 30084 PH: (404) 463-6367 FAX: (404) 463-6369
Vicki Proefrock	Regional Representative for C&A MH	East Central MHDDAD Region	4684 Oakley Pirkle Road Martinez, GA 30907 PH: (706) 863-4534 FAX: None
Kris Rice	Regional Representative for C&A MH	Southeast MHDDAD Region/ Coastal Children's Advocacy Center	PO Box 9926 Savannah, GA 31412 PH: (912) 236-1401 FAX: None
Dianne Sacks	Member-At-Large		Hillside 690 Courtenay Drive, NE Atlanta, GA 30306 PH: (404) 724-2520
Sharon Jenkins Tucker	Adult Consumer/ Executive Director	Georgia Mental Health Consumer Network	246 Sycamore St, Suite 160 Decatur, GA 30030 PH: (404) 687-9487 FAX: (404) 687-0772
Tommy Sistrunk	C&A Consumer		C/o Andre Barnes @ Inner Harbour 4685 Dorsett Shoals Douglasville, GA 30135 PH: (770) 942-2391 ext. 405

Marty Smith	State Employee- Education System Rep.	Georgia Department of Education	Division of Exceptional Students 1866 Twin Towers East Atlanta, GA 30334 PH: (404) 657-9963 FAX: None
Sue Smith, Ed.D.	C&A Service Provider	Georgia Parent Support Network, Inc.	1381 Metropolitan Parkway Atlanta, GA 30310 PH: (404) 758-4500 ext 102 FAX: (404) 758-6833
Julie Spores	Adult Consumer	Peer Support Network	3045 Scarlett Street Brunswick, GA 31520 PH: (912) 280-1510 FAX: None
Tonya Storey	Family Member of C&A Consumer	Georgia Parent Support Network, Inc.	1381 Metropolitan Parkway Atlanta, GA 30310 PH: (404) 758-4500 FAX: (404) 758-6833
Jean Toole, Ph.D.	Adult Service Provider	Community Friendship, Inc.	85 Renaissance Parkway, NE Atlanta, GA. 30308 PH: (404) 875-0381 FAX: (404) 875-8248
Shelby Torbert	Family Member of Adult Consumer		650 Owl Creek Drive Powder Springs, GA 30127 PH: (770) 875-0381 FAX: None
Cynthia Wainscott	Family Member of C&A Consumer		2274 Camden Dr. SW Marietta, GA 30064-3800 PH: (770) 424-5532 FAX: None
Scott Walker	State Employee- State Housing Agency Rep.	Department of Community Affairs	Division of Community Services 60 Executive Park South, NE Atlanta, GA 30329 PH: (404) 679-0569 FAX: (404) 679-0669
Linda Welch	Adult Consumer / Regional Representative for AMH	Southwest Region	GA Pines CSB PO Box 1659 Thomasville, GA 31797 PH: (229) 255-5214 FAX: (229) 225-4374

Table 2. Planning Council Composition by Type of Member

Type of membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	44	
Consumers/Survivors/Ex-patients (C/S/X)	9	
Family Members of Children with SED	3	
Family Members of Adults with SMI	3	
Vacancies (C/S/X & family members)	4	
Others (not state employees or providers)	9	
Total C/S/X, Family Members and Others	24	54.5
State Employees	13	
Providers	7	
Vacancies	0	
Total State Employees & Providers	20	45.5

- (3) **Planning Council Charge, Role and Activities** The MHPAC members exercise all the duties as specified in the Section 1914 (b) of the PHS Act. Such roles and duties are enumerated in the Council Bylaws that follow in this document. In preparation for the state's submission of this application, the MHPAC met and advised the state Adult and Child Planners on recommended goals and indicators for the state plan. In addition the MHPAC reviewed the completed document and provided comments on the plan. The Georgia MHPAC is very active in monitoring and reviewing services, holding Council meetings on site at provider agencies to monitor programs. Regional Council representatives review programs in their regions and report their findings to the Council.

The Georgia MHPAC works through an active committee structure. Most committees meet prior to the start of the Council meeting and report plans/actions to the full Council during the business meeting. Some committee work is also done between Council meetings, as necessary. The Monitoring and Evaluation committee of the Council reviews data reports provided by the Mental Health system and develops action plans or recommendations based on that information. This committee recommended the planned state level gap analysis of services and will provide consultation to the contractor conducting the gap analysis. The Public Policy Committee monitors legislative and other public policy initiatives and coordinates with other mental health advocacy groups to guide the advocacy work of the MHPAC. The Multi-Cultural Committee studies population and cultural trends and shifts and monitors the system's responsiveness and cultural sensitivity. This committee recommended the Cultural Competence initiative that led to the current plans for a Cultural Competence Strategic Plan. The Employment Committee monitors the success of the mental health system in increasing employment opportunities for consumers and challenges the state to undertake new challenges and initiatives.

BY LAWS OF THE GEORGIA MENTAL HEALTH PLANNING & ADVISORY COUNCIL

ARTICLE I: AUTHORITY

By Georgia Code annotated (OCGA) 37-2 establishing the Department of Human Resources in 1972 and by OCGA Chapter 37-2 establishing the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) within DHR, and according to the Public Health Services Act, Title XIX, Part B, Section 1916(e).1 resulting from Public Law 99-660, the Commissioner of the DHR through the Director of the Division of MHDDAD established the Georgia Mental Health Planning and Advisory Council in 1989.

ARTICLE II: PURPOSE

The purposes of this council are to serve as an advocate for chronically mentally ill individuals, severely emotionally disturbed children and youth, and other individuals with mental illnesses or emotional problems; and to monitor, review, and evaluate, not less than once each year, a plan for the allocation and adequacy of mental health services within the state.

ARTICLE III: SCOPE OF COUNCIL ACTIVITIES

The scope of this council shall encompass examination of the providers of state services toward provision of the best treatment available for the most-in-need chronically mentally ill adults, severely emotionally disturbed children and youth, and other individuals in Georgia with mental illness or emotional problems. The Council may utilize whatever information and assistance are available within the Georgia Department of Human Resources to effect positive change following such examination.

ARTICLE IV: MEMBERSHIP

- A. The Public Health Services Act, Title XIX, Part B, Section 1916 (e)3 specifies that the Council will be composed of residents of the State including representatives of: (1) the principal state agencies with respect to: (a) mental health, education, vocational rehabilitation, criminal justice, housing, and social services, and (b) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- B. PHSA, Title XIX, Part B, Section 1916(e) (4) further specifies that not less than 50 percent of the members of the Council will be individuals who are not State employees or providers of mental health services;
- C. Council membership will consist of:

- (1) Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related supported services.
- (2) One organizational membership for Georgia Mental Health Consumer Network, National Mental Health Association of Georgia, National Alliance for the mentally Ill-Georgia, Georgia Parent Support Network, and Georgia Prevention Network, each nominated by the respective organizations and confirmed by Council;
- (3) Two at-large representatives, who are adults with serious and persistent mental illness, nominated by membership committee and confirmed by Council, with nominations accepted from the floor;
- (4) Two at-large C&A representatives nominated by membership committee and confirmed by Council, with nominations accepted from the floor. Every effort should be made to have at least one representative who is a consumer of child and adolescent services;
- (5) One MHDDAD Regional Coordinator, nominated by the Regional Coordinators and confirmed by Council;
- (6) Two regional representatives from each of the MHDDAD Regional Planning Boards. A membership committee will select these representatives from multiple nominations made by the Regional Boards. The committee will take into account biographical data submitted by the nominees, and will assure that Council membership reflects the ethnic and cultural demographics of the state as taken from the most recent census. They will also assure that Council membership reflects the percentage of those in Georgia who need and qualify for public services by age criteria (adult/C&A), based on data from the most recent Plan.
- (7) The Director of the Division of MHDDAD and the Division's Director of Consumer Affairs will be members of Council.
- (8) Council membership will include a significant number of people with serious and persistent mental illness who are receiving or have received mental health services.
- (9) The families of such individuals.
- (10) Representatives will be designated by state agencies as described in Article IV.A.1. Council will annually review the agencies represented on Council and make needed additions/deletions.

D. The Council shall consist of not less than 24 members with terms of three years. Members can be appointed for a total of two (2) consecutive terms. After one year off the

Council, a former member can be reappointed for up to two (2) consecutive terms. State employees who represent agencies on the Council are exempt from term limits. They will serve until they fail to meet the Council attendance policies and/or a different representative is appointed by the agency they represent. *Each year, at the first meeting held after September 30, the membership committee will present nominations as proscribed above. After confirmation by Council, the proposed list of new members will be sent to the Commissioner, Department of Human Resources with a recommendation for appointment. Members whose terms expire will be removed from Council's membership list when the Commissioner appoints the new slate of members. Members representing state agencies who withdraw will notify their agency director and request that she/he notify the Council Chairperson of the re-appointment. Terms can be extended to allow for service as an elected officer of the Council. The Chair's term of office can be extended to allow for a term as past-chair.

- E. Vacancies shall be filled by Council recommendations to the Commissioner of the Department of Human Resources for appointment to fill periodically occurring vacancies.
- F. The Council members shall serve without compensation but shall be reimbursed for any and all actual and necessary expenses incurred in connection with the performance of duties authorized by the Council. After a nomination is approved by the Council and sent to the Commissioner for official appointment, the nominee is entitled to expense reimbursement.
- G. Membership attendance consists of:
 - (1) Absent from more than two (2) of any six (6) consecutive meetings will be automatically removed from membership. "Absent" is defined as not being present and not having an official, voting substitute in attendance. Attendance of a council member by electronic devices counts as official attendance. Attendance by a substitute must be in person. In order to vote on an issue, the council member must have been in attendance, as defined above, for the discussion of the issue.
 - (2) If a Council meeting date is changed with less than 10 days notice to members, an absence at that meeting will not be recorded as an absence.
 - (3) If a member cannot attend a meeting and cannot attend electronically and cannot provide a substitute, he/she can designate a proxy to be carried by the chair. If a proxy is designated, the member will not be recorded as absent.
 - (4) If a member fails to meet obligations of membership, the membership committee shall request Council recommendations for the Commissioner of DHR to appoint a replacement for that member.
- H. Each member shall designate a permanent alternate to attend council meetings in the member's place in the event of the member's absence, and to vote the member's proxy if

necessary. Alternates may attend Council meetings with their member but may not vote if the member is present at the meeting. Designation of an alternate by a member shall be made in writing to the Council Chairperson.

- I. Visitors may attend Council and committee meetings for the purpose of serving as professional consultants. Visitors do not have voting privileges.
- J. Minutes of the meeting shall reflect the names of those members in attendance, those with excused absences, those absent, and those represented by another party.

ARTICLE V: QUORUM

One-third of the Council in attendance at the time of vote at any official meeting shall constitute a quorum. The action of a majority of a quorum present at the time of voting shall constitute the action of the council. All members and official substitutes attending in the place of members are entitled to vote and the person the substitute is representing shall be counted present for a quorum. Official substitute can represent and vote in place of only one member per meeting.

ARTICLE VI: OFFICERS

- A. The chairperson shall be the principal officer of the Mental Health Planning and Advisory Council. The chairperson shall preside over all meetings of the Council, call special meetings as needed, appoint committees, and generally supervise and direct all actions of the Council with assistance from staff liaisons from the Division of Mental Health, Developmental Disabilities and Addictive Diseases. The chairperson shall be elected by the Council membership and shall hold office for one year.
- B. There shall be two vice-chairpersons elected by the Council each to serve on year terms. One vice-chairperson shall be elected to represent child and adolescent mental health issues. One vice-chairperson shall be elected to represent adult mental health issues. In the absence or inability of the chairperson, the executive committee shall decide between the two vice-chairpersons who best can perform all duties of the chairperson.
- C. A secretary shall be elected by the Council for a one-year term to oversee recording and distribution of minutes of meetings and written announcements of all meetings. The secretary shall perform other such duties as the chairperson directs and shall utilize assistance by liaison persons from the Division of MHDDAD.

ARTICLE VII: MEETINGS

- A. The Mental Health Planning and Advisory Council shall meet a minimum of four times a year. Members shall be notified in writing of the date, time, and place of the meeting at least ten days in advance.

- B. Special meetings of the Council may be called by the chairperson as necessary to fulfill the purpose of the council.

ARTICLE VIII: COMMITTEES

- A. The Planning and Advisory Council shall have an Executive Committee to include at a minimum the chairperson, the two vice-chairpersons, and the secretary. Additional members of the Executive Committee may include chairpersons of standing committees, past-chair, or other persons as may be appointed by the chairperson. The Executive Committee shall be responsible for the formulation of the meeting agenda for the full council and for the conduct of such council business as may arise and require attention at times other than during regular meetings of the full council. The minutes of Executive Committee Meetings shall be distributed to the membership of the council.
- B. The Planning and Advisory Council shall have such standing and ad hoc committees as the Council shall deem necessary for the proper conduct of its business. Such committees shall be appointed by the chairperson and shall report directly to the Council.

ARTICLE IX: AMENDMENTS

These by-laws may be amended by a majority vote of a quorum at any meeting of the Planning and Advisory Council, provided that the proposed amendment shall have been submitted in writing to the entire membership at least ten days prior to such meeting.

(4) State Mental Health Planning Council Member Comments and Recommendations

Regarding the review process:

- We received it after business hours on July 26, and did not have time to share it with all interested parties in our network, as it is due at 5pm on the 28th. More time to read and discuss this document would have been appreciated. (Randy Tucker)

Regarding typographical, formatting, discrepancies or possible factual errors in the plan:

- Page numbers would have made more specific comments feasible. (Randy Tucker)
- Sharon Jenkins Tucker is the executive director of GMHCN, and has been since March. Please correct on your member list. (Randy Tucker)
- If the priorities are listed in order, perhaps they should be numbered. (Randy Tucker)
- PEER centers? Is this an acronym? If so it should be spelled out at least once. If not "Peer" Centers would be more appropriate. (Randy Tucker)

- Additionally, if they have not picked it up there is a "typo" on the last page of Part B, Section I in the bold title beginning National...."Lining" should probably be "Living." (Carol Bush)
- In AMH, Section II, 5th page from the end of that section. I would assume that Gateway is anticipated to open in the winter of 2005 (instead of 2004). (Carol Bush)
- In the AMH section CSBs are referred to as quasi-public agencies. In the C&A section they are called public agencies. I don't know if they would like to make that consistent. (Carol Bush)
- 10th bullet under Analysis of Unmet Service Gaps/Needs..... refers to "substance abused treatment services" and should read "substance abuse treatment services". (Ron Koon)
- The first page of the Executive Summary contains the statement, [consideration is being given to adopting a "fee for service" program, perhaps as early as mid-year.] However, in Section II, Criterion 1, it is stated on page 10, [Georgia is planning to implement a "fee for service" system to replace the performance contracting that has been utilized in the past.] These two statements appear to be inconsistent - is fee for service being implemented or being considered? (Dianne Sacks)
- On page 4 on the last line of the second paragraph, there appears to be a typo – needs a "to" between "youth" and "the." (Dianne Sacks)
- On page 4, third paragraph, there is a description of Level of Care, which states it was formerly known as MATCH. I don't think this is quite accurate. Level of Care includes what was formerly known as MATCH, but also includes more. I think you need check with those who work with this program for a more accurate definition. Also, it is my understanding that level of care begins at a level above "basic care." So that it is not correct to say that it includes children with "basic care needs." I question whether wraparound is included in Level of Care. (Dianne Sacks)
- In this paragraph (p.4, 3rd paragraph) there is a statement that there has been "no focus on the community-based systems of care, as a diversion to these high intensity services." Then in the following page (page 5) there is a significant discussion of DFCS' efforts to support children in their families and communities through the PUP, PSSF, FPBP. These activities seem inconsistent with "no focus." Also, I suggest that you consider adding the Residential Treatment Project as one of the initiatives to promote services that are community-based and family-focused. (Dianne Sacks)
- Page 17, in the third paragraph, is the statement that "DMHDDAD has been given the responsibility for managing the LOC process and utilization review for youth in parental custody who are referred by mental health case managers. . . DMHDDAD will assume fiscal and administrative responsibility for these youth during FY2005." Is it correct to say this has been firmly decided, or is it still in the planning stages? (Dianne Sacks)

- In the Child and Adolescent Service System Section, there is some very emphatic language about DMHDDAD assuming responsibility for managing the LOC process, etc. for children in parental custody. While this has been discussed, it is our understanding at DFCS that no final decision has been made about this. It may be premature to include this in the state plan. (Kathleen Rinehart)
- In at least one place, wraparound is mentioned as an LOC service. At least for now, wraparound is not included in LOC. Also, the list of services in the plan under LOC should be more expansive. LOC includes all foster care provided through private agencies, not just therapeutic foster care. (Kathleen Rinehart)
- In at least one section, LOC is described as the services that were included under the old MATCH program. MATCH has been subsumed under the LOC system, which includes an array of services beginning with basic foster care. (Kathleen Rinehart)
- On a more technical note, the Georgia Department of Labor (GDOL) does not use the term "division"; therefore, we are not the "Division of Rehabilitation Services" but just "Rehabilitation Services." The "Vocational Rehabilitation Program" is one part of "Rehabilitation Services" under GDOL and is the Program which most often collaborates with service providers under DHR/DMHDDAD. (Jan Cribbs)
- Regarding Item #10 in Section I – New Developments... Please consider including “juvenile justice” in the list of agencies referenced in the first sentence. (Ron Koon)

Regarding the focus and methodology of the plan:

- The executive summary was basically good, but may imply that resiliency is not a value of adult mental health, or hope and recovery are not important for children. (Randy Tucker)
- Some terms may need to be defined better. Do you think all readers will understand the word "resiliency" in the way you intended? We can give other examples as well. (Randy Tucker)
- The goals look achievable, and we liked the tables and clear logic. (Randy Tucker)
- Methods were a little vague, but will allow much flexibility. (Randy Tucker)
- The staff did an exceptional job of presenting an accurate picture of mental health services in Georgia with the strengths and the challenges. I particularly appreciate the emphasis in the adult mental health section which points out the need for intensive case management services—ACT, CST, or CSI. To quote: “Particularly limited is the availability of Assertive Community Treatment (ACT). More work is needed to increase the numbers of ACT providers in the system.” As I see consumers coming back to the hospital frequently, I believe support in the community to assure that they take their medicines and have adequate housing and jobs would decrease the recidivism substantially—and more important, improve their quality of life.

- The child and adolescent section is comforting in documenting how far Georgia has come since 1989. However, it is very clear that we have a long way to go. By any estimate, we are not serving half the youth who are in need. I think the major actions identified as key to infrastructure improvement are absolutely correct. (Carol Bush)
- We hope that the next State Mental Health Plan will include a goal related to children in the child welfare system. It is difficult not to be troubled by the fact that the plan includes children served by DJJ, but not children in a system that is under the DHR umbrella. We know that children in the child welfare system are some of the most vulnerable, traumatized children in our communities. (Kathleen Rinehart)
- As a representative to the Mental Health Planning and Advisory Council, I am all for the "the overarching philosophy and vision of the mental health system in Georgia [being] focused on the concepts of Hope and Recovery for adults with SMI and Resiliency for children and adolescents with SED who receive services." (Jan Cribbs)
- I am concerned that adopting a "fee-for-service" program of reimbursement for providers will further hinder their ability to serve clients. It is my understanding that revenue maximization, or "RevMax," has hamstrung the 25 Community Service Boards (CSB's) that deliver "many of the services contracted by regional offices..." in that private service providers "cream off" those clients who are Medicaid-eligible and for whom they can bill Medicaid for services rendered. This leaves the CSB's with a majority, if not all, of the remaining, Medicaid-INeligible clients and has forced CSB's to bill clients for services, albeit on a sliding scale, and/or other agencies such as Vocational Rehabilitation (VR).

Traditionally, VR has often served the same clients in a reciprocal relationship with mental health service providers/CSB's, sharing records and working together, with the client, towards recovery and employment. Because both VR and the (previously known as) mental health centers were both state agencies and state-funded, no fees were charged on either side. With the privatization of all mental health service providers, including the CSB's, this has obviously changed; yet VR often cannot pay and the CSB's continue to be responsible for serving the homeless and other indigent clients who are not served by any other provider.

Thus, the CSB's are already in the position of having severely reduced State grant-in-aid funds. When they do have Medicaid-eligible clients, they have to provide services, then bill Medicaid and wait for a third-party reviewer to approve the bill, then wait for reimbursement from Medicaid to arrive. For other clients, they have to try to recoup fees for services wherever possible, either by billing the client - which may or may not be successful - or another agency, as stated above.

How can CSB's continue to operate at all without some up-front funding from the State? How can they be expected to provide services on a completely fee-for-service basis, then sit around and wait for reimbursement while their payrolls, rent, and other overhead expenses keep coming due?

SUGGESTED RESOLUTION: Give the CSB's a percentage of their operating funds "up front," to ensure their ability to keep their doors open and continue to serve clients with no Medicaid; then they can bill for those services.

Also, compensate CSB's at the same level as private providers, for similar services. That is not only fair and equitable, it also provides more substantive support to the indigent and those clients without access to Medicaid, as well as to those who serve them. (Jan Cribbs)

- I enjoyed reading the application. I feel positive about the future of mental health services in Georgia as I see the problems recognized and workable solutions proposed. We have much work to do! (Carol Bush)
- The Department of Juvenile Justice has often been referred to as the default mental health system for emotionally disturbed youth who are not adequately served by the public mental health system. I am pleased to see that the plan does acknowledge system shortcomings that are creating a need for the Department of Juvenile Justice to develop a parallel mental health system. (Ron Koon)
- As a council representative from the Department of Juvenile Justice I appreciate the plan's focus on improving service delivery for youth involved in the juvenile justice system. We support current and future initiatives for developing and strengthening cross-agency initiatives and collaborative efforts to develop effective mental health services for all youth. (Ron Koon)

GEORGIA MENTAL HEALTH PLANNING AND ADVISORY COUNCIL
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July 30, 2004

Gwendolyn Skinner
Georgia Department of Human Resources
Division of MHDDAD
Two Peachtree Street, NW, 22nd Floor
Atlanta, Georgia 30303

Dear Ms. Skinner:

The Georgia Mental Health Planning and Advisory Council reviewed the Goals and Indicators of the FY 2005 through 2007 State Plan at its regularly scheduled meeting July 6, 2004. We were pleased to have the opportunity to participate in the development of the State Plan for the FY 2005 through 2007 Mental Health Block Grant Application.

We believe that this continues to be a strong plan for mental health services in Georgia. We recognize that there have been many challenges to the mental health system in Georgia, and we as a Planning and Advisory Council will continue to be advocates for improved services to adults with serious mental illness and children and adolescents with serious emotional disturbances.

Thank you for the opportunity to review this plan and application. I want to commend the state for meeting significant challenges in this time of limited resources.

Very truly yours,

Phylis C. Holliday
Chairperson

PART C

State Plan

Section I Description of the Georgia Service System

Overview of the State Mental Health System

The Georgia Department of Human Resources (DHR) was established in 1972, combining several former independent human service agencies. It is the legally designated agency responsible for mental health, developmental disabilities and addictive diseases services and a variety of other human services. DHR is comprised of several offices and major Divisions, those being Family and Children Services, Public Health Services, Aging Services, and Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD). The DMHDDAD Director is a member of the DHR management team, where coordination and planning across health, mental health and social service programs occurs.

The Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) is established in Georgia statute to exist within DHR. The DMHDDAD is mandated to carry out certain activities including administering programs, training personnel, conducting research and protecting clients' rights. DMHDDAD's purpose regarding mental health, developmental disabilities and addictive diseases services, according to the statute, is "to develop comprehensive, preventive, early detection, rehabilitative, and treatment services; to improve and expand community service board programs for the disabled; to provide continuity of care through integration of county, area, regional, and state services and facilities for the disabled; to provide for joint disability services and the sharing of manpower and other resources, and to monitor and restructure the system of providing disability services in the State of Georgia to make better use of the combined public and private resources of the state and local communities."

In addition, Georgia statute assigns specific responsibility for developing programs for children and adolescents in need of mental health services to the DMHDDAD. The Child and Adolescent mental health program section is located in the Office of Mental Health and Addictive Diseases (MH/AD) within the DMHDDAD. The functions of this section are to provide statewide direction, planning, consultation training and technical assistance to regional staff, regional planning boards, hospital and community providers, as well as coordination with other child serving agencies. This section coordinates and collaborates with the Divisions of Public Health and Family and Children's Services within DHR, the Office of Regulatory Services within DHR, and the Departments of Juvenile Justice and Education on issues pertaining to youth with serious emotional disturbances.

The DMHDDAD is the largest division within DHR. The DMHDDAD state office provides statewide direction, planning, coordination, consultation, technical assistance, and management support to regions and publicly operated or funded mental health, alcohol, drug abuse and mental retardation programs in Georgia. Seven regional offices are responsible for contracting, monitoring and evaluating services. Regional planning boards are charged with assessing local

need and planning for services to meet the identified needs of the region. These planning boards are required to have at least 50% of their membership comprised of consumers and family members to assure the inclusion of the consumer/family voice in determining needed services for the local region. Each region is organized to encompass the community service areas relating to the state hospital within the region, with the regional office responsible for the overall operation of both community and hospital services. The service delivery system and the process for developing and contracting with providers are comprehensive in scope and focused on the value of consumer choice.

Community Services are provided through 25 Community Service Boards (CSB), that are quasi-public agencies, as well as a number of private service provider agencies, under contract with DMHDDAD through the regional offices. The CSBs are required under statute to have the same minimum 50% consumer and family representation that is expected for the regional planning boards. Consumer choice is a value that is embraced throughout the system, and is fostered through the development of different kinds of provider agencies. Agencies vary in scope of services provided, with the CSBs generally offering a full array of community services and the private provider agencies offering a variety of specialized services.

Each of the seven DMHDDAD regions has a state operated psychiatric hospital that provides acute inpatient care to adults requiring hospital treatment. There are currently three state-operated units that provide acute inpatient care to youth who are in need of stabilization services. Utilization of inpatient treatment is closely monitored and every effort is made to prevent hospitalization through reliance on community crisis centers and other crisis residential programs. Readmission to hospital services within 30 days of discharge is monitored through performance contracting for community service providers, with a goal of reducing the rate of occurrence through more focused and effective community services.

Summary of Areas Needing Attention for FY 04 and Significant Achievements

1. **System Challenges:** State FY 2004 was an especially challenging one for the state mental health system. Changes in regional configuration and governance responsibilities were accompanied by significant changes in staff roles and office locations. Regional Coordinators in several of the new regional offices were new to the state system, or were functioning in new roles. Many staff persons in the offices were also fulfilling new responsibilities for which they received limited orientation and training. New staff positions were developed to provide programmatic expertise in the regional offices. For example, each regional office was staffed with a new Child and Adolescent Mental Health/Addictive Disease Program Specialist to interface with the providers under contract, other child-serving agencies and the State MHDDAD office for more efficient communication and quality of care for youth with SED. Additionally, there is an Adult MH/AD Program Specialist position in each region to focus on service development for adults. The fact that these positions focus on both MH and AD services strengthens the ability of the DMHDDAD to address the needs of individuals with co-occurring mental illness and addictive disease. DMHDDAD state office also underwent some restructuring of offices creating a separate Office of MH and AD. There have been additional

responsibilities added to this Office including the responsibility to provide programmatic consultation to the MH/AD Specialist in the regional offices. DMHDDAD state office mental health program staff worked closely with these new staff over the fiscal year to provide technical assistance and training related to their new duties. Quarterly meetings between state and regional mental health staff provided opportunities to address system wide challenges and make recommendations for system improvements.

2. **Improving Access and Linkage to Services:** As part of the system reform and restructuring mentioned above, effort was made to improve access and linkage to services being provided across the state. A stakeholders group was convened, under the facilitation of a contracted consultant, to study the issues related to service access and linkage and to provide recommendations for consideration by the DMHDDAD. During FY 2004, the DMHDDAD incorporated those recommendations and other input into a plan for improving access to services to assure that individuals across the state have a consistent and effective means for entering service. Contracts for FY 2004 included performance expectations related to Service Entry and Linkage to facilitate improved access. Consensus planning led to development of a definition of “Core Customer” for receipt of adult mental health services that more clearly identifies those individuals who are to be served by the public service system, utilizing public funding. A definition of core customer for receipt of child and adolescent mental health services is under development and should be completed by the first quarter of this state fiscal year.
3. **Strengthening Principles of Recovery and Resilience:** The philosophical shift in service provision from clinic to rehabilitation option begun during FY 2003 continued to require close scrutiny and considerable technical assistance to implement the principles of recovery and resilience system wide. Managing Medicaid expenditures within available resources was part of this complex issue, as was provider training and service quality improvement. Layered on top of the system governance changes described above, and the economic downturn seen here and across the country, was a 10% Medicaid rate cut for all mental health services. Regional office staff worked with contracted providers to assure that consumers continued to receive the services they needed, and to focus more of the available resources on purchase of services demonstrated to provide the greatest effectiveness for consumers. With emphasis and staff training on “Principles of Recovery” throughout the system, utilization of rehabilitation based services increased, and services focused on symptom maintenance decreased. Georgia is currently addressing strategies for collecting information on homeless persons through data tracking systems to include unduplicated counts, use of services and the effectiveness of the local homeless assistance system. Meeting the needs of Georgia’s growing homeless population requires a new level of collaboration through thoughtful and effective development and implementation of homeless management information systems (HMIS). Pathways Community Network has been identified as the preferred HMIS provider that will link all homeless providers into a comprehensive referral system throughout the state. This has the potential to benefit homeless consumers by enhancing access to services while providing reliable data that will enable strategic planning and resource allocation.

4. **Improving Homeless Data Tracking:** In FY 2003, homeless data tracking was included in Georgia's performance measurement and evaluation system (PERMES) to identify those persons who were homeless at any point during the last 90 days with subsequent follow-up assessments to measure quality of life, functioning level, satisfaction, and service availability and access. In FY 2005, the statewide MIS system will identify the on-going housing status on every client when entered into any service. These data tracking efforts have provided information necessary to improve service access and expand housing and resource supports for persons who are homeless and have serious mental illnesses. At the beginning of FY 2004, mental health services specifically targeting the chronically homeless population were available in metro-Atlanta, Macon, and Savannah, covering three regions of the state. Using the 2003 PATH funding increase, the state made these services available in Columbus, adding a fourth region, and also added mental health support services for those identified as homeless upon release from prisons. During the SFY 2003, 1,726 homeless persons received benefit from a PATH funded program, with 830 of them enrolled on ongoing services.
5. **Improving Services to Youth in Out-of-Home Placements:** The DHR and the Department of Juvenile Justice (DJJ) rolled out plans to implement a Level Of Care (LOC) system for youth in out-of-home placement. The two Departments began working with Georgia's providers of residential care to create the LOC system to purchase placement services for a child, based on the child's needs. This system established payment rates based upon the levels of care needed by children and the services required to meet those needs. The LOC system is providing the framework for the state's goals of choosing the most appropriate, least restrictive placement environment for our youth, while reducing the number of moves, and decreasing their overall length of stay in out-of-home care. The six levels of care cover the entire continuum of out-of-home care provided by the private sector, from basic Institutional foster care through Intensive Residential Treatment (formerly known as Multi-Agency Team for Children-MATCH placements). The DMHDDAD Division Director, Office of Mental Health and Addictive Diseases Director, and DMHDDAD Child and Adolescent Program Chief continue to participate in planning meetings to assist with achieving tasks associated with implementation of the LOC system. DMHDDAD service providers are expected to partner to provide mental health services to youth with SED in the lower levels of care and when step down services are needed to re-integrate youth from out of home residential care back to their homes and communities.
6. **Access for Youth Served by Multiple Agencies:** Significant work has been done at the state level to develop a plan for availability of a full continuum of appropriate placements along with treatment when children cannot remain safely in their homes. Recommendations of workgroups focused on the safety of children stressed the importance of having an array of mental health services available and accessible to meet the needs of youth with SED and their families to avoid out-of-home placement or allow them to return to their communities. Much of the focus for DMHDDAD has been on expanding community-based mental health services. A need was identified for improved planning and service coordination and delivery among all child-serving agencies.

DMHDDAD at the state and regional levels has worked with other child-serving agencies to improve access to and delivery of community-based mental health services. DMHDDAD contracted with Sheila Pires, a national expert on building systems of care, to conduct training and technical assistance in each region to facilitate development of “systems of care”, as part of a statewide Quality Improvement Initiative. This initiative, “Building Systems of Care for Youth With SED,” began with a state level strategic planning session, and a series of trainings and technical assistance pertaining to building systems of care for youth with SED. The training initiative included all 7 regions, approximately 43 public and private provider agencies, representatives from child serving agencies and stakeholders including child welfare, juvenile justice, school systems, public health, consumers and family members. The introductory session was open to all providers, regional staff, and other stakeholders followed with technical assistance provided to the participants, with coaching and ongoing technical assistance. Another round of on-site follow ups allowed the regions to continue building on the strengths of their capacity building system of care strategic plans, and to identify barriers and ways to promote change in the system of care for youth with SED.

7. **Youth Transitional Services:** To better facilitate the movement of youth who are aging out of residential treatment services and returning to community services, a workgroup was created in FY 2003 to develop a protocol and policy to standardize the process. The workgroup provided local training in FY 2004 to educate key stakeholders such as adult mental health providers, juvenile justice staff and local child welfare staff on the transition process and the new protocol. In addition to the Transition Protocol and new Division policy, the transition workgroup collaborated with the Division to develop a transitional housing plan for youth who are aging out of the child and adolescent services system, either through LOC or the community services. The Department of Community Affairs (DCA) identified a number of Section 8 vouchers to be utilized by the DMHDDAD to serve “special populations” of persons with disabilities. Some of these vouchers were earmarked for serving the transitional youth population. Advertisements for properties willing to accept Section 8 are in process and communities are being identified to pilot this transitional housing plan.
8. **Staff Competencies to Serve Co-occurring Disorders:** The training for clinical staff to improve competence in treating individuals with co-occurring mental illness and addictive diseases continued in FY2004. Additional eight-month intensive training groups, as well as additional Motivational Interviewing and Cognitive Behavioral Therapy training sessions were provided to facilitate expansion of the capacity statewide to meet the needs of individuals with co-occurring mental illness and addictions. As a result of this training initiative, the state has seen an increase in the number of programs providing integrated treatment for individuals with co-occurring mental illness and addictive diseases. The state also applied for funding from the Center for Mental Health Services and the Center for Substance Abuse Treatment under the Co-SIG initiative, but while the application scored well during the review, it was not selected for funding. With SAMHSA’s reissue of the Co-SIG RFA, Georgia has again applied for funding to enhance the capacity of the service system to address this need.

9. **Movement of Consumers from Institutions to Community:** In FY 2004 the state continued work on the implementation of Georgia's *Olmstead Plan*. The FY 2004 state budget, developed in the 2003 session of the Georgia General Assembly, contained funding to implement additional projects to assist consumers in moving from institutions to community settings. For mental health, funding was appropriated to move fifteen consumers with lengths of stay longer than 60 days, out of hospitals and into community settings. The plan called for six individuals to be moved to a group home setting, and the remaining nine consumers to move into apartments with supportive services to help them to maintain their residence. By the end of FY 04 it is expected that twelve of the fifteen will be placed in the community, with the remaining three being placed in early FY 05. Another initiative related to the *Olmstead Plan* being developed through the state's ***Real Choices Systems Change Grant***, is a supported housing demonstration that will utilize fifty Section 8 vouchers to provide housing for adults with serious mental illness who are being discharged from institutional settings. Supportive services will be provided to assure the individuals' success in maintaining their housing. This project has not yet been implemented because of the difficulty encountered in identifying housing availability that will utilize Section 8 vouchers. The initiative will be carried forward into FY 05.
10. **Crisis Services for Youth:** In FY 2004, as part of the Division's Child and Adolescent Quality Improvement Capacity Building Initiative, DMHDDAD continued the crisis services improvement initiative that began in FY 2003 through a contract with the Technical Assistance Collaborative (TAC) to provide training in crisis services development to the regions and their providers that had not yet received the training. There were at least 15 public and private providers and 5 regional offices involved in this three part training series. There were also opportunities for providers to have on-site technical assistance pertaining to crisis service development and/or enhancement of existing programs. Additionally, providers of crisis residential services were offered training on development of crisis stabilization programs and offered on site technical assistance to improve or expand their crisis residential services capacity.

New Developments and Issues Affecting Mental Health Service Delivery

1. **Leadership Changes:** Georgia's Department of Human Resources (DHR) and the Division of MHDDAD both experienced changes in leadership in the last quarter of FY 2004. Governor Purdue appointed the new DHR Commissioner to her position in May 2004, following six months during which DHR had interim leadership. A new Division Director for MHDDAD was announced in mid June 2004, after six months with an "acting" director. With new leadership, it is anticipated that the state system will experience significant change, but the details of that change are not yet available.
2. **Service Delivery System Study:** In FY 2004, at the request of the governor, the Georgia Department of Audits and Accounts conducted the first phase of a study of the Community Service Board Service Delivery System. Phase I of the study focused on state level administration of the service delivery system. Phase II of the study will be

completed during FY 2005, and will focus on all aspects of the Community Service Boards' operations. Findings and recommendations from the Phase I report have led the Department and Division to examine contracting and service delivery and develop plans for improvement. Three concepts being considered for possible implementation during state FY 2005 are a "fee for service" reimbursement system, a statewide "single point of entry" call center, and validation of consumer eligibility based on newly developed "Core Customer" definitions.

3. **ERO Re-procurement:** For the past four years, Georgia's utilization of Medicaid mental health services has been monitored by a contracted external review organization (ERO). Under state procurement regulations it will be necessary to re-bid that contract during state FY 2005. At this time, it is not known what changes will ensue with the new ERO procurement.
4. **System Gaps Analysis:** At the request of the Mental Health Planning and Advisory Council, the state will be contracting with a vendor to conduct an analysis of the mental health service system capacity and gaps, to be completed during FY 2005. The resulting report will be utilized in many ways, but foremost will be the use by the MHPAC in its advocacy efforts. It is anticipated that the information will also be useful in future planning and service development efforts.
5. **Capacity Development for Co-occurring Services:** Training and capacity development for treating co-occurring mental illness and addictive diseases will continue in FY 2005. The state has again applied for COSIG funding, but plans to continue limited training and technical assistance initiatives with existing state funding, even if the COSIG application is not funded. The focus of the initiative for this year will be on expansion of programs that have been developed through the initiative during the past two years and strengthening the skills of clinicians who are currently trained. Additionally, there will be limited opportunities for introductory training for new clinicians.
6. **Cultural Competency Strategic Plan and Training:** Having both mental health and substance abuse services within the same agency (DMHDDAD) has allowed the state to more closely align many efforts that affect both groups of service recipients. During FY 2005 the Office of MH/AD staff will work with a consultant to develop a "Cultural Competence Strategic Plan" to identify both accomplishments and opportunities for improvement in the area of cultural competence. Additional training in cultural competence will be delivered to provider staff serving both populations.
7. **C&A Infrastructure:** Georgia has applied for a C&A State Infrastructure Grant (C&A SIG) from SAMHSA to help expand the state's infrastructure for developing comprehensive systems of care to meet the needs of youth with serious emotional disturbance, substance abuse and co-occurring disorders and their families. Strategies in the C&A SIG include: development of a trained workforce, funding strategies, policies and practice guidelines and web resource development and improved data infrastructure development. The overall purpose of the C&A SIG is to provide the ability to strengthen

the capacity, from a state level, to develop, expand and sustain mental health, substance abuse and co-occurring services and supports at the community-based level for youth who have serious emotional disturbances, substance abuse and co-occurring disorders and their families.

8. **Initiatives to End Homelessness:** In 2002, the State of Georgia participated in the nation's first Homeless Policy Academy to address the needs of the homeless through an initiative to improve access to mainstream services. A cross discipline team of state officials and nonprofit homeless service providers developed a *State of Georgia Action Plan to End Homelessness in Ten Years*.

On February 11, 2004, Governor Perdue signed an Executive Order to establish the Georgia Interagency Homeless Coordination Council and that it be co-chaired by the Department of Human Resources and the Department of Community Affairs. Council membership is composed of representatives from the various state departments and other homeless coordination service agencies. This Council has been empowered to oversee state efforts to address chronic homelessness and charged to review the *State of Georgia Homeless Action Plan to End Chronic Homelessness in Ten Years* and present recommendations on the implementation strategy.

9. **Level of Care Implementation:** Currently, under the aforementioned LOC System for youth in out of home placement, twenty-five percent of youth in placement are youth in parental custody. The majority of these youth are served in traditional residential treatment centers although some are served in therapeutic foster care. Placement of these youth has been managed through the same process as youth in the custody of child welfare with programmatic and fiscal administration handled through the state office of Family and Children Services. Discussions have been underway to plan for a shift of the programmatic and fiscal responsibilities to the Division of MHDDAD for parental custody youth. Mechanisms for determining eligibility and continuing stay criteria, contracting for and monitoring provider services, and utilization review and management processes will need to be developed in order for DMHDDAD to move forward with management of the LOC for parental custody youth. In addition, DMHDDAD would need to do further work on provider development in order to have available step-down resources for youth as they progress from restrictive to less restrictive settings or to their home communities.
10. **Data System Improvements:** The state's new Data Infrastructure Grant (DIG) will focus on linking our data system with that of other agencies such as Department of Labor, Corrections, Education, Medicaid, etc, to have access to such information as employment data, school performance data, involvement with justice systems. This information will allow us to track outcomes for our consumers even after they have been discharged from services. The data will be collected in a data warehouse that will make it available for reporting and measuring service effectiveness. Also as part of the DIG, the state will be conducting periodic provider surveys regarding utilization of evidence based practices and other indicators related to service quality, and will be providing additional support to

our regional offices in conducting the annual consumer survey. Successful implementation of the new DIG will better position the state to report on the mandatory and the developmental tables required in the block grant.

Legislative Initiatives and Changes

Georgia's regional MHDDAD system was originally established through legislation in 1993, with a legislative revision to the system in 2002. That revision reduced the number of regions from 13 to seven, to correspond with the state operated psychiatric hospitals, and to return contracting authority to the state. Since that time, there have been no legislative initiatives that have had impact on the MHDDAD system.

Regional and Community Programs

As stated previously, Georgia's mental health system is operated through seven regional offices that have responsibility for planning and contracting for both community services and hospital services. Each regional office has a Regional Coordinator who is ultimately responsible for assuring that needed mental health, developmental disabilities and addictive diseases services are available throughout the region. Each region also has a Regional Services Administrator who has primary responsibility and oversight for community services and a Hospital Services Administrator with responsibility for operation of hospital services. With both hospital and community services under the management of a single coordinator, continuity of care for consumers is enhanced. Subject matter expertise for mental health, developmental disabilities and addictive diseases is available through the Program Specialists in the regional offices. Each regional office has both an Adult MH/AD Program Specialist and a C&A MH/AD Program Specialist. These Program Specialists are charged with the responsibility of monitoring contracted services and providing technical assistance to provider agencies to foster quality improvement and assure compliance with contract expectations. Having Program Specialists with both mental health and addictive disease expertise is beneficial toward achieving the state's goal of providing integrated services for individuals with co-occurring mental health and addictive disorders.

The legislation that created the regional MHDDAD system, also called for the creation of Community Service Boards (CSBs) to replace the county board of health structure that had been in place previously. These boards have the same membership requirement of at least 50% consumers and family members as is required of regional planning boards. The CSBs are not state mental health authority operated, but are established in Georgia Code as public agencies "created for non-profit and public purposes to exercise essential governmental functions." CSBs can be part of county governing authorities or may be part of a limited liability company or another nonprofit entity. They are authorized to contract with DMHDDAD for publicly funded disability service delivery activities. Many of the current 25 CSBs were originally established through the Community Mental Health Center Act, and through contracts with the regional offices, have continued to provide a full array of community mental health services utilizing both state funds and Medicaid reimbursement. The CSBs that have relationships with county governing authorities also often have benefit of some local and county support for disability

services. The community service system also includes several non-profit and “for profit” private service provider agencies that enter into contracts with regions to provide mental health services. Some provider agencies are Medicaid-only providers and do not contract for state grant-in-aid funds, but applications for approval as a Medicaid provider are approved by the regional offices and service utilization is monitored by the state ERO.

State Mental Health Agency Leadership for the Broader Mental Health Service System

The DMHDDAD is heavily involved in many initiatives that coordinate mental health services within a broader mental health service system. Because of the collaborative nature of the Department of Human Resources, many initiatives flow from internal Department level work groups that involve the agencies that make up DHR. The mental health program staff in the Division’s Office of MH/AD provides programmatic expertise and direction to many of these initiatives.

MHDDAD and Division of Aging Services (DAS) have long collaborated to improve mental health services to older persons in Georgia, as well as senior citizens services to aging mental health consumers. Work has been done to establish mental health and aging coalitions in various parts of the state, to examine issues from a local perspective and enhance services to this vulnerable population. Issues of depression in the elderly and senior suicide prevention have also been addressed through these efforts. Most recently DMHDDAD and DAS collaborated on an application that was selected for participation in the *National Governors Association Policy Academy on Rebalancing Long Term Care Systems Toward Quality and Community Living and Healthy Aging*. The DMHDDAD Director will participate in this policy academy and will take the lead on the mental health issues related to long-term care.

Housing and employment are two priorities for persons with mental illness that have benefited from collaboration between the mental health agency and other parts of the service system. To better address these issues and to bring MHDDAD leadership into the forefront, a new position was established in the Office of MH/AD to focus specifically on these two priorities. This housing and employment specialist has taken the lead in coordinating supportive housing demonstration projects across the state, utilizing HUD funded housing initiatives and mental health supportive services. On the employment front, this staff member has coordinated efforts between Vocational Rehabilitation and mental health service providers to improve collaboration and coordination of efforts.

Focusing on youth being served in long term out-of-home placements, the Departments of Human Resources and Juvenile Justice have been working for the past year to create and implement LOC system that will fund services to these youth based on their level of need. DMHDDAD staff members have been active participants in the development of this initiative and took the lead in developing the array of mental health services that is included for each level of care. The LOC will assure that the intense needs of youth served by multiple agencies will be addressed in the most effective manner.

Recognizing the growing problems of individuals with mental health and substance abuse disorders who are involved with the criminal justice system, the Governor created a Task Force for Mental Health and Criminal Justice. This task force has undertaken the charge of piloting a project to focus on treatment and diversion by providing necessary treatment services in community settings and thus reducing the need for individuals to be incarcerated. DMHDDAD staff members have taken the lead in developing recommendations for services and in coordinating state and local mental health involvement in this project.

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

ADULT MENTAL HEALTH SYSTEM

Criterion 1: Comprehensive Community Based Mental Health Service System
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Strengths and Challenges for a Comprehensive Community Based Service System

Georgia provides a comprehensive community-based system of mental health care for adults with serious mental illness who need public services. The regional structure, discussed in more detail in Section I, is an important foundation of Georgia's mental health service delivery system. It fosters empowerment by ensuring greater consumer and family participation in decision-making about the system and provides opportunities for greater responsiveness to local needs for mental health services. Seven regional offices are responsible for contracting, monitoring and evaluating services. Regional planning boards are charged with assessing local need and planning for services to meet the identified needs of the region. Each region is organized to encompass the community service areas relating to the state hospital within the region. The regional office is responsible for the overall operation of both community and hospital services, which enhances continuity of care.

Community service boards are the established public providers of mental health, developmental disability and addictive disease services in Georgia. In addition to the community service boards, a growing number of private providers offer an array of community services for adults with serious mental illness. All providers must adhere to the DMHDDAD Provider Manual For Community Mental Health, Developmental Disability and Addictive Disease Providers Under Contract with the Regional Board, which includes core requirements for all providers and community standards for non-accredited providers. The requirements identified in the manual assure that an organized system of care is available to citizens of Georgia wherever they live in the state, according to individual need, and in accordance with federal block grant requirements. Services are required to be provided in a culturally appropriate and competent manner by providers with a workforce trained to recognize and address diverse needs.

Providers contracting with a Region for \$250,000 or more are required to obtain accreditation from one of the following: the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation of Rehabilitation Facilities (CARF), the Council on

Accreditation of Services for Families & Children, or the Council on Quality and Leadership in Supports for People with Disabilities (The Council). Providers contracting for less than \$250,000 are reviewed against the standards for community providers and are certified by MHDDAD.

An External Review Organization (ERO) monitors Georgia's Medicaid mental health services for utilization and appropriateness. The ERO authorizes services for specific lengths of time based on individual need and expected benefit, with reauthorization available as long as progress is documented toward individual recovery goals. Random sample reviews are conducted quarterly to assess compliance with standards, documentation and staffing guidelines, and technical assistance is offered to assist providers to improve any aspects of service delivery that fall below the quality standards. Since the implementation of the ERO, providers have steadily enhanced their own quality improvement and utilization activities resulting in improved appropriateness of care.

Since fiscal year 2000, mental health, developmental disability, and addictive disease services have been evaluated using a statewide set of identified measures as part of a program called PERMES (Performance Measurement and Evaluation System). This evaluation system has enabled MHDDAD to take a critical look at services and develop performance standards based on the evaluation data. The PERMES program utilizes nationally recognized measurement tools to evaluate service quality and effectiveness along with an extensive consumer-to-consumer survey process to gather consumer perception of services. The adult consumer survey utilized is the MHSIP consumer survey, providing Georgia with data that can be used to benchmark against other states. Many of the goals and indicators included in the Georgia state plan will be measured using PERMES data. Although there is still a need for improved provider reporting, the PERMES data has been a major benefit in performance improvement, with a focus on consumer outcomes.

In keeping with *Achieving the Promise: Transforming Mental Health Care*, the report of The President's New Freedom Commission, recommendation 5.2 Georgia continues to "advance evidence-based practices." Georgia has focused considerable attention on developing and implementing evidence-based practices within the mental health service system through dissemination of information and through pilot demonstration projects. For several years the state conducted a "Best Practices" training conference for system provider staff from throughout the state, to introduce best practice concepts for mental health, developmental disability and addictive disease services. That effort was followed by more concentrated training utilizing a learning transfer model to facilitate understanding and implementation of new service models. As a result of this emphasis on best practice, the mental health system in Georgia has implemented all of the currently identified Evidence-Based Practices (EBPs) in various parts of the state. Some of the EBPs, such as supported employment, supported housing and illness self-management (Peer Support) are available state wide.

In many ways, Georgia has taken bold steps to implement recommendation 2.2 to "involve consumers and families fully in orienting the mental health system toward recovery." Most specifically, Georgia has led the country in the development of Peer Supports as a billable

service under the Medicaid Rehab Option. As a result of the success of this program and the interest in replication across the country, the Director of MHDDAD's Office of Consumer Relations was asked to develop a "Tool Kit" on peer supports for national distribution through the Center for Mental Health Services (CMHS). The future release of this tool kit will guide other states in development of peer-operated services. Consumer provider staff is an integral part of the success of this program, and their incorporation in the staffing requirements for peer supports and other recovery-focused services is strengthened through a training and certification program. Certified Peer Specialists (CPS) are now required in the staffing patterns for ACT and Community Support Teams, as well as Peer Supports, and are recommended for psychosocial rehab (PSR) programs. In spite of the strength of the peer support services and the introduction of CPSs into the staffing mix as change agents, Georgia is still faced with the challenge of infusing recovery-focused services on a statewide level.

Georgia has been aggressive in efforts to expand supported employment services throughout the state. Both state and federal funds have been allocated specifically to expand the availability of employment services and supports. Services to help consumers secure competitive employment are based on program models designed to meet the needs of persons with a serious mental illness. Increasing the number of persons employed has been a long-term goal of the state system and continues to receive significant attention to support the recovery goals of consumers.

The Vocational Rehabilitation Program of Rehabilitation Services (RS), which is located within the Georgia Department of Labor (DOL), collaborates with MHDDAD to provide evaluation and training to help clients with disabilities obtain and maintain employment. DRS staff exchange referrals with mental health provider staff and help link clients with education, job training, and employment opportunities. The Commissioner of the Department of Labor has committed the department to provide computer labs for the MHDDAD PEER (Peer supports, Education, and Employment for Recovery) Centers being developed around the state. DRS often contracts with the PEER Centers, to do job development for consumers. The MH/AD employment expert works closely with peers at DRS to facilitate information exchange and to implement state and federal initiatives to expand employment for persons with disabilities.

In Georgia, the mental health and substance abuse programs are housed in the same agency, DMDDAD. This allows greater flexibility in planning for services to meet all the needs of an individual. Services specifically for individuals with co-occurring mental illness and substance abuse problems have been slow to develop, however. Another service specifically targeted to individuals with both mental illness and problems of addiction is the "Double Trouble in Recovery" program. This is a 12 Step self-help program based on the Alcoholics Anonymous (AA) model that recognizes the need for persons with a mental illness to continue with psychiatric medications, rather than to abstain from use of all substances. Prior to the inception of this model, persons with mental illness and problems of substance abuse were often unwelcome in the traditional AA groups unless they agreed to stop using their medications for their mental illnesses. This service, while not available throughout the state, is being offered in several regions, especially in PEER Center settings. One example is the Metro Region, which contracts with the Georgia Mental Health Consumer network to conduct Double Trouble

meetings at 16 sites across the region. These meetings are available Monday through Friday each week in the afternoon and evening to facilitate consumer participation.

Beginning with state fiscal year 2002, Georgia began piloting PEER Centers for individuals who have both mental illness and substance abuse problems. Utilizing equal portions of mental health and substance abuse block grant funds, these PEER Centers assist individuals with co-occurring disorders to gain the supports and other services necessary to enable them to achieve fuller recovery for both illnesses. This is the first program in the state to use a blended funding approach to providing a service for consumers with co-occurring disorders. This is possible because funds allocated to the regions for contracting services can be tracked through the Budget Allocation System (BAS), and contracts can be developed utilizing multiple funding streams and contract deliverables.

A close relationship exists in most areas between public physical health and mental health services. Referrals from mental health centers to county health departments are common, especially for routine health screening and immunizations. Dental and other medical services are provided primarily by the private sector, and in some instances by regional psychiatric hospitals on an outpatient basis. Thanks to cooperation among the Georgia Dental Association, the state licensing board for dentists and the DMHDDAD, a listing of dentists available to serve people with disabilities is posted on the Internet. Some 400 dentists are currently listed, and the directory is updated periodically.

Because community housing options for people with disabilities are recognized as a critical need, the DMHDDAD, regional offices and provider agencies have been collaborating for several years with the Department of Community Affairs (DCA) to secure Housing and Urban Development (HUD) funding and state housing funds to expand the available options. Many new individual apartment and group home opportunities have been established through these efforts. For example, in cooperation with the DMHDDAD, DCA developed successful statewide HUD applications beginning in FFY 1999, and continuing through the current HUD application cycle, resulting in significant new resources for Shelter + Care projects in many parts of the state. This program is only available in areas of the state included in the statewide Continuum of Care Plan, and as such represents primarily rural regions of the state. Some provider agencies in larger communities have been successful in working with local continuums of care for additional housing. To make housing available to even more individuals with disabilities, DCA provided specialized Section 8 vouchers to DHR and MHDDAD to provide additional housing opportunities for persons with disabilities. More details of the housing collaboration activities between MHDDAD and DCA are included in the narrative of Criterion 4, when discussing efforts to address the needs of individuals who are homeless and mentally ill. Most recently, DCA collaborated with DMHDDAD to conduct a conference that included MHDDAD state and regional staff, service providers and housing developers to explore additional ways to expand housing options within Georgia.

Free, appropriate public education is available in the Georgia public school system to all students, ages 3-21, with disabilities. For those individuals between the ages of 18 and 21 who have not completed public education, transition services are mandated through an Individualized

Education Plan (IEP) that will assist individuals to move to appropriate post-school services and supports. Students and parents are involved in the development of the IEP. Services under the plan include: (1) specialized instruction, (2) functional vocational evaluation, (3) development of employment linkages, (4) adult living objectives and (5) interagency linkages. Additional educational opportunities for adults older than 21 are being developed and offered in conjunction with the PEER Centers. These include General Equivalency Diploma (GED) preparation and computer classes.

A variety of other sources of community support are available to adults with serious mental illness. Community Support workers assist consumers and their families in accessing and coordinating services from other state Department of Human Resources divisions, including the Division of Family and Children Services, the Division of Public Health, and the Division of Aging Services. Consumer, family and other advocacy organizations have become increasingly significant in providing consumers with supports for recovery, in establishing consumer employment as a top priority, and in impacting policy decisions concerning mental health service delivery. Most notable of the service delivery changes recently is the implementation of the Rehabilitation Option for the State Medicaid plan, which has been a goal of consumers, families and advocates for many years. Through the PEER Centers and other peer support activities, effort is being directed toward the development of “natural” supports for individuals in their local communities. This has included partnerships with organizations such as one with Habitat for Humanity, which resulted in building a home for a mental health consumer. Many groups and organizations came together to raise the necessary funding for this home, and then to build it, dedicate it and assist the consumer to move in to his own home.

Case Management provides for each consumer with a serious mental illness an assigned and accountable professional or paraprofessional staff person who is known to the consumer within the agency. This employee serves as a point of contact and an advocate for the consumer in obtaining services he or she needs within or outside the agency. This service is available in each region and service area in Georgia. The six functions of case management are (1) identification and outreach; (2) assessment of needs; (3) service planning to meet all treatment and community support needs; (4) linking to assure consumers’ access to providers of services; (5) monitoring to ensure that services are provided and are adequate and appropriate; and (6) advocacy to overcome barriers to service and to fill gaps in the service system. Within the range of “case management” services in the state system, these functions are provided to each consumer through service authorization based on level of need.

Beginning July 1, 2001, Georgia moved to the Rehab Option for the state’s Medicaid plan for mental health services. Under the new Medicaid plan, there are expanded levels of case management available to consumers. There are three services that represent different types of case management, (1) Assertive Community Treatment (ACT), (2) Community Support Team, and (3) Community Support Individual. Consumers will receive service based on intensity of need, with ACT being the most intense level of service and Community Support - Individual being the least intense level. Consumers with greater needs will be authorized for ACT, with consumer-to-staff ratios of approximately 10:1. Consumers authorized for Community Support Team services are those whose needs are less intense, and consumer to staff ratios are

approximately 15:1. Those individuals with the least intense level of need will be authorized for the Community Support Individual level of service, with ratios of approximately 30:1.

Over the past fourteen years, Georgia has been working to reform its mental health system and to move from heavy reliance on inpatient hospital services to increased community services. During that time period, inpatient beds were reduced by more than 50%, and one inpatient facility was completely closed. Funds that had been supporting hospital services were reallocated to community services, and Days of Active Client Enrollment (DACE) were reduced significantly, as were number of inpatient admissions.

Georgia's psychiatric hospitals function primarily as short-term, acute care facilities, with the goal of returning consumers to their communities for services as quickly as possible. Although hospital bed capacity and length of stay have been greatly reduced, Georgia continues to struggle to meet the challenge of high readmission rates and increased forensic admissions.

Related to persons with mental illness and institutional placement, another important aspect of the mental health service system is the Preadmission Screening and Resident Review (PASRR) program administered by Medicaid. In Georgia, the Department of Community Health (DCH) has the lead in managing this program, but MHDDAD has responsibility for the Level II screening to determine nursing facility appropriateness and need for "specialized services." That process is conducted through a contracted provider with oversight by MHDDAD. Delivery of "specialized services" is contracted by DCH to a second provider, which delivers the recommended level of services to each individual determined to require such care.

For persons with mental illness who have been incarcerated in state prisons and are being released on probation or parole, DMHDDAD and the Georgia Department of Corrections (DOC) have collaborated on an initiative known as TAPP, Transition and Aftercare for Probationers and Parolees. What began as a pilot in one region of the state was found to be so successful that funding from both agencies was pooled to replicate the program throughout the state. TAPP is a program of linkage and case management that engages individuals prior to release from prison, and assures that they become engaged in community services upon their release. Pre-release planning and linkage to community services has greatly reduced the number of individuals who have re-offended or violated terms of their probation causing them to return to prison, and has strengthened the relationship between DMHDDAD and criminal justice agencies.

One of the biggest challenges to the Georgia system is the size and diversity of the state. The state of Georgia with its 159 counties occupies the largest land area east of the Mississippi River. Approximately 77% of the state's counties are very rural, with great distances to travel to access services. Many of these rural areas are also designated by the Health Resources Services Administration (HRSA) as "Health Professional Shortage Areas," making recruitment and retention of qualified staff for mental health service provider agencies a difficult task. Recent service mapping by staff in the Office of MH/AD revealed gaps in service availability across the state. The service areas in each of the seven MHDDAD regions encompass multiple counties, with most services being available primarily in the "lead" county of the service area, particularly in the more rural parts of the state. While some services are provided through satellite locations

and others are provided “out-of-clinic,” access to services can present a challenge for individuals who reside in the more remote parts of the service areas. The metropolitan areas also face service access challenges due to burgeoning populations and limited financial and staff resources to provide enough service to meet the ever growing need.

Related to the problem of service access is the issue of transportation, especially in rural areas of the state. In Metro Atlanta, public transportation is readily available for persons to access both services and employment. However, outside of the Atlanta area, in smaller cities and the rural areas, public transportation does not exist. Individuals who are eligible can sometimes access Medicaid transportation to mental health and other health related services. When ever there are opportunities for consumers of service to comment on the service system and the challenges that they face, transportation is generally the most frequently cited barrier to service accessibility.

Analysis of Unmet Service Gaps/Needs and related Data Source

With a population of 8,186,453, according to the 2000 census, Georgia is the tenth most populous state in the nation. The ethnic/racial composition of the state is approximately 65% white, 29% black, and 6% other (primarily Hispanic and Asian). Information from the 2000 Census also shows that Georgia has experienced one of the largest population increases of individuals who are Asian, Hispanic or members of another ethnic minority group, and those populations are continuing to grow. Cultural and language specific services for ethnic minority groups are extremely limited, and mental health professionals who speak languages other than English are few. Georgia has limited capacity to provide special services for individuals with sensory impairments that would limit access to services. A recent study by the Georgia Council for the Hearing Impaired (GaCHI) identified significant gaps in service delivery to individuals who are deaf or hard of hearing.

Yet another group that is seriously under-represented in receiving services are those who are age 65 and older. DHR’s Division of Aging Services (DAS) provides a number of social and health services for this population, but access to mental health services is limited due to several factors. Chief among them is the fact that many elderly persons are unwilling to seek mental health care due to the stigma and shame they feel related to mental health services. Too often issues of late life depression and other mental illnesses go unrecognized by primary care physicians, and individuals are not referred to services. Reports from DAS indicate that many of the older individuals they serve through Medicaid Home and Community Based waivers exhibit symptoms of mental disorders, and Community Care workers are unfamiliar with how to connect these individuals to services. The public mental health system provides very few specialized programs for these older persons, and much of the current service array focuses on interventions to help consumers get jobs and other supports that do not interest individuals who are older and who have retired.

Georgia has significant problems with poverty, with an average per capita income that places the state 34th in the nation in this category. Over the past three years the state has also faced heavy unemployment and large budget deficits. Because of diminished revenue collections in this time period, funding for all state programs and services has been cut, to comply with the

constitutional requirement to balance the state budget. The state mental health authority has not seen growth in funding for adult mental health services for several years, and while the population has increased, the resources to provide mental health services have remained static, if not declining. New service development has been funded through redirection of funds from state hospital services or through the growth in Medicaid funded services for those who are eligible as well as through the mental health block grant increases. This has limited the ability of the system to expand services to address many of the gaps that are identified above.

Affordable housing for persons with disabilities continues to be a challenge to the service system. As discussed in the preceding sections, many efforts have been and continue to be made to address this need, but market rates for rental property in Georgia are very high. A 2001 study conducted by Ann O'Hara for the Consortium for Citizens with Disabilities Housing Task Force, titled *Priced Out in 2000*, shows Georgia's fair market rental rate to be so high that persons living on SSI would require greater than 100% of their income to pay rent. In year 2000, the average percent of SSI benefits needed to rent a one-bedroom housing unit in Georgia is 104.7%. In metro Atlanta that same housing would require 133.2% of SSI income. While some communities do have more affordable rental rates, the availability of housing stock is generally limited, making it difficult to locate appropriate residential options.

While Georgia is moving forward with training initiatives to develop provider capacity to provide integrated treatment for persons with co-occurring mental and substance use disorders, the state's information system is not able to collect data on the number of consumers who have both diagnoses. At this time, the information system can only capture one primary diagnosis, so reporting numbers of individuals with co-occurring mental illness and addictive disease must be done by determining numbers of persons with mental health diagnoses receiving services from an addictive disease provider and vice versa. This creates an unrealistically low estimate of service need for this population.

Georgia is expanding efforts to address the needs of persons with mental illness who become involved with the criminal justice system, but the numbers needing services are far greater than the system has the capacity to serve. This is evidenced by the growing numbers of persons with mental illness in local jails and state prisons, as well as by the number of individuals who have been found Not Guilty by Reason of Insanity (NGRI) or Incompetent to Stand Trial (IST) and who require treatment in one of the state psychiatric hospital forensic units. MHDDAD is currently examining this issue and developing plans for community services that will enable some individuals to leave inpatient settings on "conditional release," and also divert some individuals from hospital services who could be served in a secure community setting.

State Priorities and Plans to Address Unmet Service Gaps/Needs

Recognizing that the Georgia mental health system has many critical gaps and unmet service needs, the Georgia Mental Health Planning and Advisory Council (MHPAC) requested the state to contract with an outside consultant to conduct a "gaps" analysis, to identify the gaps and make recommendations for keeping the data current for future assessment of need. The state will shortly be awarding a contract for this study, which will be completed in time for use by the MHPAC to advocate for service system improvement during future legislative sessions.

Information from the gap analysis will be utilized by the state in developing plans to address any unmet needs.

Mental Health needs of older persons will receive increased attention through the state's participation in the *National Governors Association Policy Academy – Rebalancing Long Term Care Systems Toward Quality Community Living and Healthy Aging*. The DMHDDAD director and the Director of Division of Aging Services will both serve as members of the state team to develop plans to improve access to all services needed by elders in Georgia. The goal for mental health improvement is to improve the coordination and delivery of mental health services for older adults as it relates to the treatment of mood disorders, primarily depression, as well as anxiety and co-occurring disorders. This will include the development of treatment protocols and improved collaboration between state services and primary care and/or family practice physicians.

Leadership of MHDDAD has been meeting regularly with leadership within the Department of Human Resources to plan for overall service system improvement. As discussed in Section I, there are several initiatives being considered to foster system improvement and to better utilize the service resources that are available in the system. The overarching priorities that are guiding this process include identifying the “Core Customer” for the public system, providing effective services that enable consumers to achieve improvement in their lives, and assuring that services are uniformly accessible throughout the state.

Recent Achievements Reflecting Progress

In its recent reorganization, MHDDAD created a staff position in the Office of Mental Health and Addictive Diseases (MH/AD) to focus on housing and employment. The concept is to have staff expertise available to provide technical assistance to regional office staff as well as to provider agencies, to further expand supported employment programs and facilitate more consumers gaining competitive employment. In addition, specialized curriculum has been developed for the CPS training program to better prepare peer specialists to support consumers who are going to work. This new position will also take the lead in collaborations with DCA to increase housing options for persons with mental illness.

The report of the President's New Freedom Commission in recommendation 4.3 challenges states to “screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.” To facilitate more cross training of mental health and addictive disease provider staff to accomplish this recommendation, MHDDAD instituted a significant training initiative beginning in state FY 2003. Contracting with Kathleen Sciacca, a training consultant with national prominence and recognized expertise, Georgia has provided both large overview trainings and more intensive clinical trainings that utilize on-going supervision with smaller groups of clinicians. This initiative has fostered the development of several integrated treatment programs within both mental health and addictive disease provider agencies in several parts of the state. This training initiative will continue for the coming year to further strengthen the capacity of provider agencies to provide integrated services to persons with co-occurring mental and substance use disorders.

Much of the aforementioned reduction in inpatient bed utilization was made possible due to the introduction of Crisis Stabilization Programs (CSP) in the communities. The CSPs are designed to provide crisis intervention and stabilization to consumers in their local communities, in many instances eliminating the need for an admission to a state hospital. Georgia continues to work to improve linkage between hospital and community services and to improve planning for discharge to community living. One of the initiatives developed to improve compliance with the Supreme Court's Olmstead decision is a training program for hospital staff in the concepts of Person Centered Planning (PCP). We are beginning the second year of this initiative with a focus on implementation of the PCP process with every individual who has been in the hospital for greater than 60 days.

There have been many initiatives to develop programs that result in jail diversion for persons with mental illness who face charges in the criminal justice system. Several communities have developed mental health courts on the model of the court in Broward County, Florida that has been shown as a model for this population. In 2002, the Georgia General Assembly appropriated funding to establish a pilot "Treatment Court" that addressed both mental health consumers and persons with addictions who face charges in the criminal justice system. Funding from both the mental health and substance abuse block grants was added to the state appropriation to launch this initiative. This and other courts operating with diversion plans and services, is increasing the number of individuals who receive services in lieu of incarceration.

Plans for the Future

Georgia is making plans to implement a "fee for service" system to replace the performance contracting that has been utilized in the past. Rather than contracting with providers for set funding amounts based on historical service capacity, providers would be paid for units of service provided to individual consumers. This would put services funded with state grant-in-aid on the same footing as those funded by Medicaid.

To improve service entry and linkage, the state is also considering implementing a statewide call center to perform the Single Point of Entry services. This function has varied by region in the past, creating inconsistencies within the system from region to region. With the mobility of consumers and their tendency to move from place to place, understanding the system for service entry and linkage in a different location presented significant challenges. This change would ensure that individuals throughout the system know how to access services regardless of where they live.

With the development and implementation of a new Core Customer definition (described in Criterion 2), the system plans to implement a new eligibility process. Planning is currently underway to develop eligibility guidelines and financial and income criteria that will be utilized in determining a fee structure and consumer co-pay schedule.

Criterion 2: Mental Health System Data Epidemiology

Strengths, Challenges and Gaps of the Mental Health System Data Epidemiology

The most relevant strength of the MHDDAD system related to this criterion is the recent development of a new service definition for adult mental health services. Because of growing pressure for services using the public dollar, it became imperative to identify those who are eligible to receive services, and the level of services to be offered. The Georgia DMHDDAD has just completed work to better define the population of adults to be served utilizing state and federal resources, within the public mental health system. With the input of consumers, providers, advocates and MHDDAD staff, a new “Core Customer” definition was developed and is being implemented for the first time with the beginning of the new state fiscal year (SFY 2005). This new definition has as its foundation the elements of the federal definition for SMI.

Under the adult “Core Customer” definition, adults age 18 and older seeking mental health or addictive disease services must have a behavioral health diagnosis on Axis I in accordance with the latest edition of the DSM and a level of functioning that is significantly affected by mental illness or addictive disease. Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted.

Screening will be made available to all adults age 18 and older who are seeking services. This will consist of a brief assessment of an individual’s need for services to determine whether there are sufficient indications of a mental illness or addictive disease to warrant further evaluation. If sufficient indications of mental illness or addictive disease are not found, appropriate referral to other services will be provided. If the individual does appear to have a mental illness or addictive disease, a comprehensive evaluation will be completed that will include both diagnostic and functional components. Information gathered during the comprehensive evaluation is used to identify the treatment, rehabilitation and recovery supports needed by the individual.

Following evaluation, some individuals will be recommended to receive **Brief Intervention and Stabilization**, services that are provided in six visits or less. Individuals in this category of service are those who have a diagnosis or diagnostic impression on Axis I mental disorder or addictive disorder. The person’s functioning must be significantly affected by the disorder; and/or the person displays behaviors that are disruptive to the community and the family/support system; and/or the person displays behavior that demonstrates a substantial risk to self or others.

Other individuals will be assessed as requiring **On-going Support and Recovery**. Individuals qualifying for this level of service must have a severe mental illness as identified by a diagnosis such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorder that is persistent and requires ongoing and long-term support and treatment. The prognosis indicates a long-term, severe disability, and without supports, hospitalization is

probable. The individual's ability to function must also be significantly affected by the mental disorder to the point that there is impairment in activities of daily living with inability to function independently in the community, as evidenced by problems in at least four functional areas of a person's life.

Georgia utilizes the published federal prevalence estimates as the basis for a determination of the percentage of the adult population with serious mental illness. The 2000 US Census Bureau Report shows the state population age 18 and older as 6,017,219. Utilizing the prevalence rate of 5.4% produces an estimate of 324,930 adults in Georgia who may experience a serious mental illness and need some level of service. During state fiscal year 2004, a total of 100,822 adults were served in Georgia's mental health system. Poverty or financial need is also factored in to determine need for services from the public system. For those who meet diagnostic and functional eligibility for services, a financial need determination is being developed that will establish cost participation rates for services. This factor will be employed as the state moves to a "fee-for-service" delivery system, which is anticipated to occur during state fiscal year 2005.

Another strength of the Georgia system related to data reporting is the Medicaid ERO. The current ERO contractor has established the capacity for "web-based" reporting of Medicaid service data. This system provides the state with encounter data for the Medicaid population that can be used to generate estimates for system level service needs and trends. The information collected about consumers served including diagnosis, functioning, and frequency of service can be reported in many ways. These reports enable system managers to study service trends and other factors by individual consumer, diagnostic grouping, provider agency, region, state or any of several other criteria. In addition, the ERO provides technical assistance to provider agencies to help them improve their reporting and to utilize the information that is gathered to do quality improvement and to identify service needs.

The PERMES program for system evaluation represents another strength in the area of data collection and utilization. Georgia's consumer-to-consumer survey is one of the largest in the country and produces useful information about the quality and accessibility of the service system. In addition to the survey data collected by PERMES, providers are required to administer and report functional assessment information on each individual served. The data from these instruments is used to report and evaluate outcomes of treatment for consumers served.

One of the biggest challenges to the state's ability to estimate incidence and prevalence of serious mental illness and to set quantitative targets to be achieved in implementing the comprehensive system of care is the ability to gather and report accurate data. MHDDAD's existing information system does not have the capacity to collect encounter data, making it difficult to accurately determine numbers served. The state Management Information system (MIS) only captures enrollment data, and if providers fail to release an individual from services upon completion, it will appear that the individual is continuing to receive services. It is also difficult to gather data from other systems, such as corrections and labor, to identify individuals served by those other systems.

The state MIS system is also not able to capture information on consumers who have co-occurring mental illness and addictive disease, or any other co-occurring illnesses. The system only allows for one primary diagnosis for each individual, which is often changed when an individual enrolls in a different service. The only way the MIS system can identify individuals with co-occurring disorders is to sort the data by consumer unique identifier to determine if someone with a primary MH diagnosis later enrolls in an addictive disease service, or vice versa. This process produces an unrealistically low estimate of the prevalence of co-occurring disorders among the individuals served by the system.

State Priorities and Plans to Address Unmet Service Gaps/Needs

While the austerity of the last few fiscal years has delayed obtaining new information systems, funds have recently been identified to allow DHDDAD to begin that process. In the meanwhile, DMHDDAD is utilizing the Data Infrastructure Grant (DIG) to develop the capacity to collect the data necessary to meet the block grant data reporting requirements. The new DIG is planned to create a data warehouse that will enhance the state's ability to receive and utilize information from other systems. With data from systems such as Department of Labor or Department of Corrections, comparisons can be run to identify MHDDAD consumers involved with criminal justice, or to determine the number of MHDDAD consumers in the labor force.

To better identify the number of providers delivering integrated treatment to individuals with co-occurring mental and substance use disorders, the state conducted a provider survey during FY 2004, asking about services to this population. The data produced through this survey enabled the state to begin recognizing the capacity and the gaps in this category of service. The survey will be repeated in FY 2005 to see what progress is being made in expanding service availability.

Plans for the Future

Because of state procurement requirements, it will be necessary for the state to re-bid the ERO contract during state fiscal year 2005. Plans are currently in development to define the scope of work to be performed by the new vendor that will be included in a new Request for Proposals. The anticipated procurement release for bids is the first quarter of FY 2005, with an expected start date of January 2006.

Criterion 4: Targeted Services to Rural and Homeless Populations

Strengths and Challenges of the Service System Targeting Services to the Homeless And Rural Populations

There is a strong correlation between mental illnesses and homelessness. A recent study by the Urban Institute found that approximately 46% of people who are homeless have a mental illness. In 2001, Congress directed the Department of Housing and Urban Development to take the lead in collecting data on the extent of homelessness in America. This includes unduplicated counts on the use of services and the effectiveness of the local homeless assistance system by 2004.

Two new data sources for tracking homelessness are being implemented in Georgia to meet this mandate. One of these includes the use of Pathways Community Network as the preferred homeless management information system (HMIS) to link all homeless providers into a comprehensive referral system throughout the state. A second new data source is the “point-in-time” counts, which are taking place throughout the seven (7) Continuum of Care jurisdictions.

In FY 2003, the state started tracking the housing status for those consumers entering and exiting the public mental health delivery system through Georgia’s performance measurement and evaluation system (PERMES). Sampling those enrolled and discharged from the system of care, a functional assessment was used to identify those persons experiencing an episode of homelessness within the past 90 days. With DMHDDAD continuing to focus on issues related to homelessness, the state committed to making homelessness a service priority with a plan to identify the on-going housing status for all adult consumers. In FY 2005 the statewide MIS system will replace PERMES in gathering homeless data with an on-going identification of the housing status for all mental health consumers each time entered into any mental health service.

Fulton is the most densely populated county in the state with the greatest concentration of the homeless population. Faced with the challenge of serving such large numbers of homeless mental health consumers, in FY 2001 the General Assembly appropriated funding to develop a specialized ACT “like” team in Fulton County to provide comprehensive community based treatment to homeless persons with intense levels of mental health and substance abuse problems. This mobile service known as the HOPE team, provides culturally competent and recovery based diagnostic support, clinical service, case management, and outreach service by traveling daily to heavily populated shelters in metro Atlanta, as well as local hospitals and jails. To further the continuum of support services for homeless people, FY 2001 Mental Health Block Grant funds were used to develop a street based HOPE team to address the needs of those individuals who are less likely to participate in existing homeless assistance programs or shelters due to severe disengagement from society related to length of homelessness and mental health and/or substance use.

The Projects to Assist in Transition from Homelessness (PATH) funding has made it possible to increase service capacity in the larger metropolitan areas of the state by developing specialized mental health teams in metro Atlanta, Macon, Savannah, and Columbus to engage the chronic homeless population and link and transition them to mainstream resources. In 2003, PATH funds were used to expand Transition and Aftercare for Probationers and Parolees (TAPP) services to include those verified as homeless upon release from the Georgia prison system. Macon expanded homeless services by developing a special Homeless Outreach Team to serve the homeless identified by jails, hospitals, and shelters to ensure these individuals with special needs are linked to mental health and addictive disease services and enrolled in entitlement benefits. In 2004, the City of Columbus received PATH funds to develop a highly trained Homeless Outreach Team including an advanced degree clinician, a case manager, and a Peer Specialist prepared to address the complicated needs of this challenging population. Savannah expanded Peer Outreach to work in concert with the existing unified case management system by adding a second full-time Consumer Specialist to engage more chronic homeless who resist utilizing traditional homeless services. Several metro Atlanta providers fund outreach and case

management teams that take mental health support services to the various shelters and homeless gathering locations.

Long-term stability for those homeless adults with a serious mental illness is only possible with access to supportive housing. Those who rely upon state supported services lack the resources to pay fair market rents, particularly in the metropolitan areas of the state. This requires rental assistance or rent subsidies allowing the tenant to enter into a lease agreement with no income while applying for entitlement benefits, and then paying no more than 30% once approved for SSI/SSDI. The Department of Human Resources works collaboratively with the Department of Community Affairs (DCA), that state agency that is primarily responsible for housing development, in developing subsidized supportive housing for those verified as homeless. From 1999 to 2003, a total of thirty-one (31) DHR provider agencies partnered with DCA to provide permanent supportive housing to homeless persons with disabilities under HUD's Shelter Plus Care Program. In that time, 41 grants allocating funds totaling \$18,943,591 have been awarded to produce 617 new housing units for homeless persons with 307 units dedicated to those with a mental illness, and 163 units for those with co-occurring mental illness and substance abuse disorders.

Rural is defined as those counties not included in Metropolitan Statistical Areas (MSA). Six of the seven MHDDAD regions have rural areas within the region, and one of those is entirely rural. As such, service to persons living in rural localities is of primary concern to Georgia. Mental health service planning for rural areas occurs at a local level through the regional office. With the implementation of the Rehabilitation Option, an expanded array of services can be delivered outside of the clinic setting including Assertive Community Treatment (ACT), Community Support Team (CST), and Community Support Individual (CSI) and in many instances within closer proximity to the consumer, including their home. The traditional model of ACT, with a strong team identity for services, is tested heavily in rural areas in which staff travel long distances to see consumers. Less intense levels of mobile service are also being implemented as an alternative including CST and CSI. A healthcare professional shortage in rural areas of the state affects the ability to develop service capacity for those services that require credentialed staff. The issue of travel is a challenge for mobile community support teams operating in rural areas. The challenge is to implement these model approaches to service in cost efficient ways and also promote access to services for all consumers in need.

That service most needed to assist adults with mental illness in rural areas is transportation. The DHR Unified Transportation System (UTS) was implemented on January 1, 2000 in order to create a more efficient transportation network, and is now operational in 91 counties in each of the seven regions. The purpose of DHR-UTS is to create a self-supporting community transportation network for improvement and expansion of services to the DHR client population. Transportation is locally planned and managed with emphasis on: safety, dependability, affordability, accessibility, and convenience for consumers. The unification/coordination of transportation involves all DHR Divisions including Aging, Family and Children Services, Mental Health/Developmental Disabilities/Addictive Diseases, and Public Health. Each Division has a defined criterion for eligibility, which are those:

- who meet eligibility criteria for "most-in-need"; and

- who have no other reasonable and affordable means of getting to and from services outlined on the consumer's Individual Service Plan and approved by a physician.

Analysis of Unmet Service Gaps/Needs and Related Data Source

In 2001, an analysis by APS Healthcare, Inc. on the number of credentialed staff among community service boards in Georgia revealed some regions having far fewer available licensed staff than others, and that up to 30% of those licensed staff were administrators who performed no direct service. The one region identified as entirely rural reported the fewest number of credentialed staff at 90. This credentialed workforce shortage impacts the ability to provide those services in rural areas of the state that require credentialed staff.

In 2003, Georgia's statewide continuum of Care Gaps Analysis determined that 5,117 homeless persons were not able to receive needed shelter. It is extremely difficult to serve homeless people unless they have a stable place to live and access to needed services, which they cannot get unless they have a steady source of income. The greatest unmet need for the homeless population remains the availability of safe and affordable housing. Outreach, case management, and the treatment for co-occurring disorders have been identified as essential services in ending the homeless cycle by supporting consumers in maintaining their recovery and housing yet these services often present a shortage in capacity. For a variety of reasons, many people who are homeless are not accessing mainstream services to which they are entitled. A 1996 national study found that only a small percentage (11%) of those eligible for entitlements receive assistance. Typically, homeless populations face barriers in applying for, retaining, and using services of mainstream programs. Finally, there remains an urgent need for local jails and court systems to prevent or reduce criminal behavior by providing mental health treatment as an alternative to incarceration.

In FY 2005, DHR plans to conduct a mental health services gaps analysis by collecting and analyzing data that will be used to demonstrate mental health service needs for individuals of all age groups residing in Georgia and compare that information with the mental health system service capacity and utilization to determine the level of unmet need. The gaps analysis will specifically address issues related to serving the homeless population and those living in rural areas.

State Priorities and Plans to Address Unmet Service Gaps/Needs

In September 2001, Georgia participated in the federally sponsored Homeless Policy Academy in order to develop a state plan for ending homelessness. The state's Homeless Policy Team presented the *State of Georgia Action Plan to End Homelessness in Ten Years* to the Office of the Governor in December 2002 for consideration. The State priorities and plans for addressing homelessness are identified in the *State of Georgia Action Plan to end Homelessness in Ten Years* and include the following:

- Expand access to and use of the federal mainstream support service programs through assertive entitlement benefits enrollment efforts;

- Provide housing for chronically homeless individuals with contractual coordination between housing funders and service funders;
- Develop and adopt state policies to end the discharge of institutionalized individuals by requiring agencies to assure appropriate housing and service linkage;
- Develop a local collaborative planning model of how integrated housing and homeless service delivery strategies can be implemented at the community level and develop and conduct training workshops for other communities to promote the replication;
- Engagement of State leadership in the implementation of these recommendations; and
- Fully utilize available federal and other funds available to address the needs of the homeless.

A statewide strategy for PATH services is to strengthen outreach and engagement activities designed to target the chronically homeless population. The plan for accomplishing this goal includes improving the ability to identify the hard-to-reach; focusing on relationship building approaches; and applying integrated interventions that are sensitive to cultural diversity. Georgia values the team approach to case management and promotes those outreach teams that go into the street, shelters and familiar homeless gather locations. Peer Specialists with homeless experience are integral members of the teams and are used to provide direct service as their unique contribution promotes dignity, respect, acceptance, integration, and choice. Advanced degreed clinicians provide clinical expertise while the paraprofessional team member's access and coordinate resources.

In December 2002, the City of Atlanta Homeless Commission was formed following a SAMHSA led challenge to mayors in major metropolitan cities across the nation to end homelessness. United Way of Metropolitan Atlanta lead a broad effort to analyze the issue of homelessness resulting in developing a *Blueprint to End Homelessness in Atlanta*, which includes 29 prioritized projects with seven projects identified for immediate implementation.

Transportation to services is the most frequently cited barrier to services in rural areas. A current statewide service priority for adult mental health is to expand the availability of transportation services. In FY04, \$10.8 million dollars was spent on the DHR transportation service to make this service available in all seven MHDDAD regions. The Georgia General Assembly allocated \$600,000 to purchase replacement vehicles in community MHDDAD programs.

The FY 2005 gap analysis of the mental health service system will help identify unique needs and gaps in services for homeless and for rural consumers. The contracted consulting group will produce a final report that will be used to guide members of the Mental Health Planning & Advisory Council in their federally mandated role of advocating for improved services during the Georgia General Assembly Session of 2005, and for the DMHDDAD use in service planning for the FY 2006 and future years planning and contracting cycles.

Recent Achievements Reflecting Progress

The DHR-Unified Transportation System provided 1.27 million trips or 41% of the total transport trips provided to more than 4,866 MHDDAD consumers in FY 2004 to ensure access to

the public delivery system. Many of those receiving transportation services were individuals residing in rural areas.

Georgia has been successful in the implementation of new data sources that provide reliable data to assist in the planning and allocation of resources to best reach those experiencing homelessness in the state. Currently, more than 180 homeless service organizations are participating in this state supported HMIS information system known as Pathways Community Network, and in 2003 this HMIS coordinated the care for 95,193 people statewide. In FY 2003, Georgia's Performance Measurement and Evaluation System (PERMES) measured for the first time the homeless status for those mental health consumers surveyed upon public service system enrollment. In this first year, an estimate of 5% of those enrolled in community service reported having experienced homelessness. The 2003 Metro Atlanta Tri-Jurisdiction Collaborative Homeless Census and Survey, covering the City of Atlanta, Fulton County, and DeKalb County was launched partly in response to the Congressional requirement that state and local governments receiving funds under the McKinney Homeless Assistance Act must conduct regular point-in-time counts of their homeless populations by 2004. The total number of persons identified on March 11, 2003 as homeless unsheltered (street and institutional count) and homeless sheltered (emergency shelter, transitional housing) was 6,956. Using a point-in-time annual multiplier of 2.39, it could be estimated that approximately 16,625 persons experienced homelessness in the Atlanta Metro area sometime during 2003.

On February 11, 2004, Governor Purdue established the Georgia Interagency Homeless Coordination Council to oversee state efforts to address chronic homelessness and review proposed recommendations from the *State of Georgia Action Plan to End Homelessness in Ten Years*. The Office of Planning and Budget has already begun to conduct a cost/benefit analysis of the current supportive housing programs in Georgia and to prepare a projection of the overall costs and benefits of implementing the Ten Year Homeless Action Plan.

The Commission on Homelessness in Atlanta has remained diligent in implementing the action plan *Blueprint to End Homelessness in Atlanta*. The top ranked initiative is a 24-hour support center called Gateway. This resource will serve as the point of entry to comprehensive homeless services and will include drop-in services, health care services, and four residential programs with a total capacity of 289 to serve the mentally ill, addictive, and medically fragile populations. Gateway is anticipated to open in the winter of 2004 - 2005.

Changing to the Medicaid Rehab option for mental health services has allowed the system to develop an array of services that can be delivered outside a clinic setting. This has been a boon to individuals in rural areas, as services can be brought to their homes or to other community settings that are more accessible.

Plans for the Future

The needs of Georgia's growing homeless population will not be met without effective collaboration since there is not enough funding within any one institution to meet this growing crisis. It will require collective planning and collaboration among providers to develop a plan to

deliver a multitude of services that will enable homeless persons, each with unique circumstances surrounding their homelessness, to end his or her cycle of homelessness. Through the guidance of the Georgia Interagency Homeless Coordination Council, major state departments will come together to discuss fundamental changes in the way agencies can share information and resources, reduce barriers, coordinate and improve existing services, and develop new programs to improve the availability, quality, and comprehensiveness of services. Many of these changes will come about through the implementation of the *State of Georgia Action Plan to End Homelessness in Ten Years*.

In 2005, Georgia will receive additional PATH funds that will be used to expand existing homeless services in various parts of the state, and to support the Atlanta Commission on Homelessness through the addition of outreach and case management services. In addition, the 2004 Mental Health Block Grant increase is being used to provide outreach and engagement services attached to Gateway, a program of the Commission on Homelessness, to ensure 24/7 service access by homeless and chronically homeless persons in Metro Atlanta.

Greater focus will be given to the types of services delivered to adult mental health consumers residing in rural areas. Providers will be encouraged to provide more out-of-clinic services such as ACT, Community Support Team (CST) or Community Support Individual (CSI), all of which can be delivered in the consumer's home if necessary. The state plan will include a goal to increase the number of consumers served in rural areas utilizing these services.

Criterion 5: Management Systems

Strengths and Challenges of the State's Management Systems

Federal mental health block grant funds in the amount of \$5,206,056, federal PATH funds in the amount of \$948,500, and State funding of \$150, 415, 069 are budgeted to be allocated to regions for state FY 2005 for community services for adults with serious mental illness. Regional offices will select providers, contract for services and monitor service outcomes in community mental health service areas. Funds will be used for service priorities identified by regional planning boards as well as for statewide priorities. Regions are encouraged to utilize block grant funds for new and innovative services for which there may not be another source of funding. Most regions utilize a portion of their block grant funds for services to assist consumers in gaining employment. Several regions utilize these funds for consumer-operated services, such as peer supports or the more comprehensive PEER Center. Tables showing the provider agencies contracted by regions for services utilizing block grant funding in FY 2004 as well as the agencies with which regions will contract utilizing block grant funding in FY 2005 are included in Section III, Criterion 5 of this document. Services provided by each agency using block grant funds are also indicated on the tables. It is expected that similar expenditures will occur in FY 2006 and FY 2007, but tables for those years will be updated in the applications for each year.

State funding for adult mental health services has remained constant for the past several years. In the late '80's and early '90's, significant new state appropriations were made to support the

development of a core set of services in “target areas” around the state. That effort to infuse a consistent mix of services throughout the state was completed in 2000 through redirection of hospital resources as inpatient utilization was reduced. Since the completion of the “target area” initiative, adult mental health services has only received two small appropriations, one for creation of an ACT team to provide outreach to homeless individuals with mental illness in the Metro Atlanta area, and a second for piloting a treatment court for diverting individuals with mental illness or addictive disease from the criminal justice system.

During the 2001 session of the Georgia General Assembly, the decision was made to apply for a change in the state Medicaid plan, moving from services provided under a Clinic Option to services provided under a Rehabilitation Option. The governor and members of the General Assembly determined that this change would enable the state to take fuller advantage of federal resources available under the Medicaid program, making state dollars available to implement new programs of service. This change became effective with the state’s fiscal year 2002, which began on July 1, 2001. This change has allowed the state to offer an expanded array of services in settings other than mental health centers, greatly enhancing the scope and focus of the service system. With this shift, the DMHDDAD also received the Medicaid “State Match” dollars in its budget, and for the first time became “at-risk” for managing the utilization of Medicaid mental health services.

Since July 1, 1999, DHR, in partnership with the regions, has contracted with a single, independent External Review Organization (ERO) to monitor services and assess whether people are getting the services they need from the right providers for as long as they need. The ERO ensures that the services are of high quality with effective outcomes, which support the philosophies of rehabilitation and recovery. Included in their review are factors such as staffing credentials and ratios, as required by service standards. Service requirements, including staffing expectations are established in the Provider Manual, and are the same for Medicaid and state funded services. The ERO data assists the regions and providers with service problem identification and resolution. The review organization continues to work closely with DMHDDAD and its providers to assure an effective and efficient Medicaid mental health system. This impacts the total mental health system since federal law requires that there be no distinction between Medicaid and non-Medicaid services.

All community staff providing services have credentials that satisfy DMHDDAD policy and guidelines and state licensing laws. State standards require a staff development program within each contracted community mental health program. Providers are required to have policies, plans, and practices to evaluate and improve staff competencies, including disability, age, and program specific competencies with attention to best practices and new technologies in services and supports delivery. In addition, all staff must have training in ethics and cultural competence. Standards include minimum requirements for a staff development program.

MHDDAD recognizes the critical importance of staff development and training. To that end, a training coordinator was employed to facilitate the many training and development activities that are offered through DMHDDAD. During FY 2004 149 training events were offered with 3,500 participants from across the state. Some training initiatives are generated in response to gaps and

challenges identified by the Medicaid ERO, in an effort to improve the clinical skills of staff in the system. Other initiatives are developed as a result of quality improvement activities. An example of a QI driven training initiative is the Sciacca training and consultation related to integrated treatment of persons with co-occurring mental and addictive disorders. A quality improvement project identified the limited ability of providers to serve such a challenging population, and resources from adult mental health as well as from addictive disease budgets were identified to launch the initiative. In the two years that this initiative has been underway, a total of 467 clinicians have participated in eleven training events.

Recognizing the tremendous growth in ethnic minority populations in Georgia, the Mental Health Planning and Advisory Council urged the state to assess the base-line levels of cultural competency among the providers of mental health services and to determine what training could be helpful in raising those levels. Utilizing Mental Health Block Grant funds, the state contracted with Georgia State University's Department of Anthropology to conduct an assessment of providers and to develop a plan for training of provider staff. This assessment and training initiative is completed and has been followed by a joint initiative with the addictive disease section to further expand cultural competence training for provider staff and to develop a cultural competence strategic plan that will guide these efforts for the future. These efforts will enable the state to comply with Recommendation 3.1 in *Achieving the Promise* to "improve access to quality care that is culturally competent."

Another recommendation from the report of the President's Commission on Mental Health is 5.3, which challenges the system to "improve and expand the workforce providing evidence-based mental health services and supports." Georgia has actively sought to improve its workforce to better deliver quality services. With the introduction of several new services through the implementation of the Medicaid rehabilitation option, a need was identified for a new classification of staff. Certified Peer Specialists were designated as required staff for Assertive Community Treatment teams, Community Support Teams and Peer Supports and were recommended for Psycho-social Rehabilitation. Beginning July 1, 2002, providers were required to employ "Certified Peer Specialists" in these roles. In order to provide a pool of qualified applicants for these positions, the state, through a contract with the Georgia Mental Health Consumer Network, developed a training and certification program for Peer Specialists. While several states have utilized Peer Specialists in service provision, this is the first certification program to be developed anywhere in the country. Block grant funds support a staff position in the Georgia Office of Consumer Relations to develop implement and monitor the certification program. Additionally, block grant funds are employed to conduct the training and continuing education activities.

Georgia provides mental health services through a system of seven regional offices. These regional offices are responsible for developing plans for all services in their area based on local assessment of need, and then contract with providers to deliver the identified services. Each regional office develops the plans and then contracts for the training of the emergency service personnel in its region, to assure the understanding of the unique needs and characteristics of the people served in the MHDDAD programs. The specific contract language and the personnel to be trained vary according to the identified need of the regions. In addition, partnering with the

National Alliance for the Mentally Ill (NAMI) Georgia, several regions are seeking training for law enforcement personnel in the Memphis model of Crisis Intervention Training (CIT). In this model, officers are trained to identify the symptoms of mental illness in individuals experiencing a crisis, and to seek appropriate services rather than to incarcerate such persons. Regions expect that this training will improve the response of law enforcement to crisis situations involving mentally ill individuals, and will decrease incidents of injury for both consumers and officers.

Analysis of Unmet Service Gaps/Needs and Related Data Sources

The Office of the Governor commissioned a study of the Community Service Board service delivery system in 2003, and the Phase one report of the study was issued in February 2004. This report identified that Georgia ranked 43rd in mental health expenditures for 2001, based on the NASMHPD Research Institute State Profile report. The same NASMHPD report was again cited to show that Georgia's average per capita spending actually declined by 0.9% between 1990 and 2001. With growing populations seeking services from the public mental health system and static funding, the gaps in service availability can be expected to increase.

State Priorities and Plans to Address Unmet Service Gaps/Needs

As stated earlier, Georgia is preparing to contract for an independent review of service gaps that will address not only the services needed compared to what services are provided. The study will also look at system capacity and staff competencies to identify training and service improvements that are necessary. The MHPAC will use the results of the analysis to advocate for service system improvement, including necessary fiscal and staff resources. The state will utilize the information to facilitate planning for future years.

Recent Achievements Reflecting Progress

Georgia has trained and certified more than 200 Certified Peer Specialists for employment in the state service system. This new cohort of service professional is functioning very successfully as change agents, moving the system toward a recovery focus, and helping consumers to recognize the need to become partners with clinical staff in designing their own treatment goals for recovery. To further make the transition to a recovery focus in the state system, training in "Principles of Recovery" was provided to staff in each of the 25 CSB programs across the state.

Using a nationally recognized consultant, Georgia has conducted a two-year training initiative to expand the skills of clinicians treating persons with co-occurring mental illness and addictive disease. This training initiative has been so well received that more than 200 clinicians were wait-listed for admission to the training.

Plans for the Future

Georgia has made application for the CoSIG grant to expand training and capacity of providers to deliver integrated services for individuals with co-occurring mental and substance use

disorders. Whether the CoSIG is funded or not, Georgia plans to continue the Sciacca training for clinicians treating persons with co-occurring disorders.

Georgia will also continue training and certifying peer specialists to work in adult mental health recovery focused services. The state has applied for a CMS Real Choice Systems Change grant to strengthen the supervisory relationship between consumer staff and their non-consumer supervisors. If funded, attention will be directed to skills building for both the CPS and the supervisor to better incorporate the CPS position into the mental health system.

CHILD AND ADOLESCENT SERVICE SYSTEM

CRITERION 1: Comprehensive Community Based Mental Health Service System

Strengths and challenges for a Comprehensive Community Based Service System

Georgia provides a comprehensive community-based system of mental health care for children and adolescents with serious emotional disturbances (SED) and their families who need public services. The regional structure, discussed in more detail in Section I, is an important foundation of Georgia's mental health service delivery system. It fosters empowerment by ensuring greater consumer and family participation in decision-making about the system and provides opportunities for greater responsiveness to local needs for mental health services. Seven regional offices are responsible for contracting, monitoring and evaluating services. Regional planning boards are charged with assessing local need and planning for services to meet the identified needs of the region. Each region is organized to encompass the community service areas relating to the state hospital within the region. The regional office is responsible for the overall operation of both community and hospital services, which enhances continuity of care.

Community service boards are the established public providers of mental health, developmental disability and addictive disease services in Georgia. In addition to the community service boards, a growing number of private providers offer an array of community services for children and adolescents with SED and their families. All providers must adhere to the DMHDDAD Provider Manual For Community Mental Health, Developmental Disability and Addictive Disease Providers Under Contract with the Regional Board, which includes core requirements for all providers and community standards for non-accredited providers. The requirements identified in the manual assure that an organized system of care is available to citizens of Georgia wherever they live in the state, according to individual need, and in accordance with federal block grant requirements. Services are required to be provided in a culturally appropriate and competent manner by providers with a workforce trained to recognize and address diverse needs.

DMHDDAD funds services to children and adolescents with SED and substance abuse disorders and their families. Youth with SED have diagnosable mental, behavioral, or emotional problems, which are persistent and interfere with their family life, community activities and school. They need a range of treatment and support services that allow them to live at home whenever

possible, continue school and take part in community life and childhood activities. Youth with substance abuse problems have diagnosable substance abuse disorders as a primary diagnosis and many have both SED and substance abuse co-occurring disorders that need specialized treatment interventions and approaches.

Providers contracting with a Region for \$250,000 or more are required to obtain accreditation from one of the following: the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families & Children, or the Council on Quality and Leadership in Supports for People with Disabilities (The Council). Providers contracting for less than \$250,000 are reviewed against the standards for community providers and are certified by MHDDAD.

An External Review Organization (ERO) monitors Georgia's Medicaid mental health services for utilization and appropriateness. The ERO authorizes services for specific lengths of time based on individual need and expected benefit, with reauthorization available as long as progress is documented toward individual treatment goals. Random sample reviews are conducted quarterly to assess compliance with standards, documentation and staffing guidelines, and technical assistance is offered to assist providers to improve any aspects of service delivery that fall below the quality standards. Having this external review organization has strengthened provider services by encouraging a focus of tying services to the individual needs of children.

Since fiscal year 2000, mental health, developmental disability, and addictive disease services have been evaluated using a statewide set of identified measures as part of a program called PERMES (Performance Measurement and Evaluation System). This is a major strength of the system. This evaluation system has enabled MHDDAD to take a critical look at services and develop performance standards based on the evaluation data. The PERMES program utilizes nationally recognized measurement tools to evaluate service quality and effectiveness along with an extensive consumer-to-consumer survey process to gather consumer perception of services. The C&A consumer survey utilized is the MHSIP Youth Satisfaction Survey (YSS), providing Georgia with data that can be used to benchmark against other states. Additionally, for the past three years, the DMHDDAD has utilized a PERMES Family Satisfaction survey (MHSIP YSS/Family Survey). Families of youth currently enrolled in services are randomly surveyed to measure satisfaction in areas such as access to services, being involved in service planning and perceptions of improved functioning, resulting from service delivery. Many of the goals and indicators included in the Georgia state plan will be measured using PERMES data.

Since the early nineties, DMHDDAD has made efforts to expand and develop a broad array of community-based mental health services for youth with SED and their families. The array includes outpatient services, community support services (case management), intensive family intervention services, crisis intervention services, after school therapeutic services, respite care, and community residential treatment services. Even with this available array, DMHDDAD recognizes a need to build further capacity for service delivery. The service expansions implemented thus far were based on a statewide strategic plan developed in the late eighties. The

first funding for child and adolescent service expansions based on this strategic plan was appropriated by the state legislature in FY 1989 and totaled \$450,000. To date, just over half of the planned expansions have occurred and have primarily been funded with new state appropriations, redirection of funds from hospital services to community services, and Mental Health Block grant funds. Currently there is over \$45 million dollars in state and Mental Health Block Grant funds available from DMHDDAD for these child and adolescent mental health services. This funding does not include revenue generated through use of the Medicaid Rehabilitation Option and other third party revenues such as the State Child Health Insurance Program (SCHIP). The SCHIP Program in Georgia is modeled after the Medicaid Rehabilitation Option Program. Youth and their families eligible for SCHIP receive the same services as eligible Medicaid Rehabilitation Option service recipients with the exception of non-emergency transportation. Over \$46 million is spent through the Medicaid Rehab Option for mental health and substance abuse services to youth.

DMHDDAD also offers a very limited array of adolescent substance abuse treatment services through regional contracts with providers. Service expansions in adolescent substance abuse services have not kept pace with expansions for adult mental health or child and adolescent mental health services. Currently, Georgia has limited outpatient substance abuse specialty services and providers, limited in home case management and specialized substance abuse therapy services, limited substance abuse and day treatment services, student support services, family services and eight (8) adolescent substance abuse residential treatment centers to provide services to youth with primary substance abuse disorders and their families. Due to this dearth of resources and the need to expand substance abuse treatment services, little attention has been given to funding specialized treatment services such as services for youth with co-occurring disorders. Youth with co-occurring disorders are typically served within the community child and adolescent mental health programs. In recent years, a few specialty programs for youth with co-occurring disorders consisting of limited outpatient counseling and after-school therapeutic programs have been developed. Additionally, the adolescent substance abuse residential treatment centers report serving youth that have both substance abuse and SED related issues and are often referred by the juvenile court system. These services are primarily funded by state grant-in-aid and federal Substance Abuse Prevention and Treatment Block Grant dollars. The total funding for these services is over \$14 million.

Substance Abuse prevention funds are allocated to the seven DMHDDAD regions for primary prevention services and programming. Based on annual plans incorporating an assessment of regional needs, each region contracts for prevention services. Several regions have implemented multiple science-based model programs. Each region determined its own service priorities based on local need and have chosen to focus on youth between the ages of 7 and 17 and their families. Among providers of services and programs under all prevention strategies were Community Service Boards, schools/school systems/boards of education, Family Connection Partnership collaboratives, drug-free community coalitions and other prevention coalitions, community and faith-based organizations, local Boys and Girls Clubs, public housing authorities, city/county parks and recreation departments, and Boy and Girl Scout programs. Prevention programs have been implemented and are being provided in 154 of Georgia's 159 counties. Geographic coverage is a function not of the lack of programs in each region, but of the extent to which

quality, science-based programs are available in each county for specific prevention needs of the target populations. Full coverage is challenged by the lack of qualified prevention providers capable of implementing science-based programs. It is important to note that of the total number benefiting from prevention programs in 2002, less than 1 percent were persons with disabilities, children of substance abusers, individuals with mental health problems, or runaway or homeless youth. This is of concern to DMHDDAD and planning is underway to explore strategies to target funding and expand prevention efforts toward these specialized populations.

Under the Medicaid Rehabilitation Option, services can be provided in schools, child welfare offices, public health offices, juvenile detention centers, juvenile courts, homeless and emergency shelters, youth and family homes and foster homes. In addition, there are expanded levels of out of clinic, community based services available to youth with SED. There are three services that represent the newest treatment approaches that move away from traditional clinic based services for youth with SED. (1) Intensive Family Intervention (IFI), (2) Community Support Team, and (3) Community Support Individual. Youth receive service based on intensity of need, with IFI being the most intense level of service and Community Support Individual being the least intense level. Case management/service coordination services are available through these three service options in each region and service area in Georgia. Within these services youth can benefit from the essential case management functions of service planning and linking, and monitoring to ensure adequacy and continuity of care. These services are provided to each youth through a service authorization process based on level of need. Youth with greater needs will be served through IFI with a consumer to staff ratio of no more than 12 families per team. Youth authorized for Community Support Team or Community Support Individual will be served through a consumer to staff ratio of 15:1 and 30:1 respectively. One area of concern with the new team services is that the Medicaid reimbursement rate is the same for IFI and CST, however, IFI requires higher levels of credentialed staff and teams must carry smaller caseloads than CST's. Therefore, many providers have chosen to provide CST services that limit the intensity of services that could be provided to targeted families and youth through available IFI services.

For youth in need of out of home residential treatment, there are services available through DMHDDAD and the Division of Family and Children Services (DFCS). DMHDDAD operates two Outdoor Therapeutic Programs, residential treatment services where youth and staff live together in a wilderness environment. There are 100 spaces available at two locations with 20 of these available for girls at one location. Additionally, there are 23 reserved for youth committed to the Department of Juvenile Justice (DJJ). DMHDDAD also has two adolescent specialty hospital units with a total of 38 beds for youth needing longer-term residential treatment. These units also reserve 8 of the 38 beds for youth committed to the Department of Juvenile Justice who are in need of intensive residential treatment. There are additionally, four state operated transition homes with a total capacity of 8 affiliated with each of the long-term specialty units for youth ready for discharge but not yet ready to return to their communities. The homes strengthen the states availability to transition youth to the community.

The DHR's new Level of Care Program (LOC), administered by DFCS, purchases out of home placements, including intensive and intermediate residential treatment, therapeutic foster care,

basic group home care and basic foster care provided by private agencies. The former Multi-Agency Team for Children (MATCH) program was subsumed under the new LOC. There is over \$100 million in funding for out of home residential services. This funding, administered through child welfare, is comprised of state revenue dollars, Title IV-E, and Medicaid funds. The LOC pool currently funds only out of home placements for youth with SED and behavioral disorders and youth who are in state custody with basic care needs. DFCS, under the former MATCH program supported an initiative in FY 2002 called the Residential Treatment Project to promote services that are community-based and family-focused and to provide training and technical assistance to a selected group of residential providers regarding step down and reintegration to community settings for youth in long term residential treatment services. This is a priority population for all of our child-serving systems for diversion and return from out-of-home placements, and will require focused state level planning for strategies to develop step down alternatives and increased community based capacity to decrease the number of youth referred to the LOC System.

Over the past fourteen years, DMHDDAD has been working to reform its mental health system and to move from heavy reliance on inpatient hospital services and out of home placements to increased community services. During that time period, inpatient beds were reduced from 200 child and adolescent inpatient acute care beds in seven regional hospitals to 70 beds in three regional hospitals. Funds from the closure of the hospital beds were utilized to support community-based service expansions. The occupied bed days (formerly known as DACE) and the average length of stay have decreased dramatically for child and adolescent hospital services. Georgia's psychiatric hospitals function primarily as short-term facilities, with the purpose of evaluation, crisis stabilization and acute care treatment. Although hospital bed capacity and length of stay have been greatly reduced, Georgia continues to struggle to meet the challenge of rising readmission rates and out of home placements.

Youth with SED and their families have multiple needs and are often served through other child-serving agencies. DFCS provides foster care, protective services and adoption services in addition to the Level of Care services aforementioned. Most of the children receiving these services have experienced the trauma of neglect or physical, emotional or sexual abuse; and a significant portion of them are youth with SED. DFCS provides mental health services to youth with SED through referrals to public mental health services or to the private sector. In addition, some foster care funds are used for the Preventing Unnecessary Placement Program, and can be used to purchase alternative in-home support services to prevent the need for removal of children from their homes. DFCS also works with community-based agencies providing a variety of services to children and families through the Promoting Safe and Stable Families Grant. This Program provides funding for the purchase of family support, family preservation, time-limited reunification services and adoption promotion and support services to ensure the safety, permanency and wellbeing of children. DFCS also provides for a comprehensive assessment of all youth entering foster care through the First Placement/Best Placement process. This process focuses on early and continuous assessment of the strengths and needs of children and their families, case plan development with the family and the use of a full continuum of services that best meets the unique needs of children in the least restrictive setting possible. One of the challenges that the system of care faces includes the lack of service linkages for youth in

foster care to mental health treatment services. In the Federal Child Welfare Review of Georgia, like many states, an area needing attention identified was the well being of children in foster care as relates to their physical and mental health needs. DMHDDAD is working with DFCS to address this area of concern through the development of goals and indicators as part of the Program Improvement Plan development process.

The Division of Public Health also provides services to youth with SED and their families. A close relationship exists in most areas between public physical health and mental health services. Referrals from mental health centers to county health departments are common, especially for routine health screening and immunizations. Older youth with multiple needs are served through Public Health's Children's Medical Services Program and Adolescent Youth Development Centers, with younger children at risk of emotional disturbance served through the Babies Can't Wait Program, Georgia's Part C Program. One area of concern includes the lack of systematic Early Periodic Screening Diagnosis and Treatment screenings in Georgia. The President's New Freedom Commission on Mental Health report has also identified lack of systematic mental health screenings for all youth as a nationwide problem and a goal was developed to address this issue. The DMHDDAD child and adolescent mental health program staff and the Public Health state office staff, including a mental health/substance abuse specialist, meet regularly to address issues across the public health and mental health services systems. Statewide training on Social and Emotional development was conducted from May 2004 through August 2004 and included public health providers and mental health providers. In addition, DMHDDAD staff is participating on a panel to address mental health issues for Georgia's Public Health Association's annual conference in September 2004.

The Department of Juvenile Justice (DJJ) also provides services to youth with SED and their families, who are involved with the juvenile court system. In a recent study, over 60% of the youth served by juvenile justice had diagnosable mental health and/or substance abuse disorders. In response to the growing demand for services, a federal investigation and subsequent Memorandum of Agreement with the Justice Department, DJJ created an Office of Behavioral Health. The Director of this Office is responsible for mental health and substance abuse services for youth detained in the short-term Regional Youth Detention Centers (RYDCs) and the longer-term Youth Development Centers (YDCs). There are currently 21 RYDCs and 8 YDCs in the state. DJJ is also responsible for providing education services to youth in their facilities. Youth committed to DJJ are served in secure and non-secure settings such as but not limited to YDCs, RYDCs, specialized residential treatment services, and multi-service centers. For specialized residential treatment services, DJJ is also participating in the new LOC process. DJJ contracts with private and public providers for intermediate and intensive residential treatment services, specialized sex offender treatment services, therapeutic foster care, and wrap-around services for youth committed to the department. An area of concern for the DMHDDAD and the DJJ is the duplication of mental health services for youth involved with the juvenile justice system. As DJJ has received increased commitments of youth with mental health diagnoses, the Department has had to develop mental health service capacity within their agency. In addition, juvenile court judges often view the juvenile justice system as a default mental health system for youth. Often times, judges will commit youth to the DJJ's custody if other mental health or substance abuse services are not readily available.

The Department of Education provides for a free and appropriate public education for all students with disabilities ages 3-21. Students identified as having emotional and/or behavioral disorders receive special education services within the 180 local school systems around the state. Students with serious emotional and behavioral disorders receive services from the Georgia Psycho-educational Network, which is supported by state and federal funds. There are 24 psycho-educational programs throughout the state that provide diagnostic evaluations, therapeutic classrooms, and transition services. The local school systems also provide special education and related services to students who meet eligibility criteria for other disability categories such as learning disabilities, intellectual disabilities and orthopedic impairments. Many of these children may be SED, but are served educationally through these other programs. For students between the ages of 14-21, transition services are mandated through an Individualized Education Plan (IEP) that will address appropriate post-school services and supports. Students and parents are involved in the development of the IEP. Services under the plan include: (1) specialized instruction, (2) functional vocational evaluation, (3) development of employment linkages, (4) adult living objectives and (5) interagency linkages.

The Vocational Rehabilitation (VR) Program of the Department of Labor collaborates with DMHDDAD to provide evaluation and training to help consumers obtain and maintain employment. VR staff exchange referrals with mental health provider staff and help link consumers with education, job training, and employment opportunities. VR is working with schools to assist with transition planning of youth with disabilities to employment. Additionally, VR has committed to assist with planning for youth aging out of residential treatment who are in need of training and employment. All youth in residential treatment who turn 17 years of age while in treatment, receive transition planning facilitated by the regional MHDDAD Offices. Local VR staff participate in transition planning with other providers to begin planning for the youth's return to the community.

Analysis of Unmet Service Gaps/Needs and Related Data Sources

Georgia has significant problems with poverty, with an average per capita income that places the state 34th in the nation in this category. Over the past three years the state has also faced heavy unemployment and large budget deficits. Because of diminished revenue collections in this time period, funding for all state programs and services has been cut, to comply with the constitutional requirement to balance the state budget. In addition, state FY2004 was the first year since the late eighties that an increase in funding for community-based child and adolescent mental health services did not occur. As the population continues to increase, child and adolescent mental health services continue to be under capacity and under funded. The state capacity building plan to expand child and adolescent mental health services was never fully funded. The first phase of plan development was funded over a ten-year period, from 1989 until 1999. The second phase of plan development was begun in 2000 and is still not yet complete. As a result Georgia has only been able to serve approximately one-third of the youth estimated to have a serious emotional disturbance.

In addition to needing additional resources to fund expanded services, Georgia is faced with the challenge of topography. One of the biggest challenges to the Georgia system of care is the size

and diversity of the state. The state of Georgia with its 159 counties occupies the largest land area east of the Mississippi River. Approximately 77% of the state's counties are very rural, with great distances to travel to access services. Many of these rural areas are also designated by the Health Resources and Services Administration (HRSA) as "Health Professional Shortage Areas," making recruitment and retention of qualified staff for mental health service provider agencies a difficult task. Recent service mapping by staff in the Office of Mental Health and Addictive Diseases revealed gaps in service availability across the state. The service areas in each of the seven MHDDAD regions encompass multiple counties, with most services being available primarily in the "lead" county of the service area, particularly in the more rural parts of the state. While some services are provided through satellite locations and others are provided "out-of-clinic," access to services can present a challenge for individuals who reside in the more remote parts of the service areas. The metropolitan areas also face service access challenges due to burgeoning populations and limited financial and staff resources to provide enough service to meet the ever- growing need.

Related to the problem of service access is the issue of transportation, especially in rural areas of the state. In Metro Atlanta, public transportation is readily available for persons to access both services and employment. However, outside of the Atlanta area, in smaller cities and the rural areas, public transportation does not exist. Individuals who are eligible can sometimes access Medicaid transportation to mental health and other health related services.

In addition, with a population of 8,186,453, according to the 2000 census, Georgia is the tenth most populous state in the nation. The ethnic/racial composition of the state is approximately 65% white, 29% black, and 6% other (primarily Hispanic and Asian). Information from the 2000 Census also shows that Georgia has experienced one of the largest population increases of individuals who are Asian, Hispanic or members of another ethnic minority group, and those populations are continuing to grow. Cultural and language specific services for ethnic minority groups are extremely limited, and mental health professionals who speak languages other than English are few. Georgia has limited capacity to provide special services for individuals with sensory impairments that would limit access to services. A recent study by the Georgia Council for the Hearing Impaired (GaCHI) identified significant gaps in service delivery to individuals who are deaf or hard of hearing.

State Priorities and Plans to Address Unmet Service Gaps/Needs

Recognizing that the Georgia mental health system has many critical gaps and unmet service needs, the Georgia Mental Health Planning and Advisory Council (MHPAC) requested the state to contract with an outside consultant to conduct a "gaps" analysis, to identify the gaps and make recommendations for keeping the data current for future assessment of need. The state will shortly be awarding a contract for this study, which will be completed in time for use by the MHPAC to advocate for service system improvement during future legislative sessions. Information from the gap analysis will be utilized by the state in developing plans to address unmet needs. In addition to the gap's analysis project through a contracted vendor, the state office mental health program staff are conducting regional service mapping to identify gaps in services across the child and adolescent mental health and adult mental health community-based

services systems. The service mapping also includes point in time data indicating numbers of consumers served, dollar amounts that were allocated to individual providers for each service category, and contract data to indicate expected outcomes. The DMHDDAD plans to use the service mapping project as a tool for the state and regional offices to map progress in service expansions, management of information systems data entry issues and to explore ways to address gaps in services across the 159 counties in Georgia.

DMHDDAD will also participate in a Mental Health Task Force formed by two advocacy organizations. The Mental Health Services Coalition, a state advocacy organization and the Georgia Association of Homes and Services for Children both had approached the DMHDDAD regarding the lack of mental health services for youth and indicated a desire to participate in planning for an improved mental health service delivery system for youth to promote service expansions and advocate for additional resources. The newly configured Mental Health Taskforce for Children will identify needed areas for reforming the children's mental health system in Georgia. The initial goals of the Taskforce are to create a plan to include development of a statewide vision for behavioral health services in Georgia and to implement the recommendations of the Governor's Action Group for Safe Children, specifically a more coordinated and integrated service delivery system that includes mental health services.

Recent Achievements Reflecting Progress

Georgia has focused considerable attention on developing and implementing best practices within the mental health service system. Early on during implementation of expanded child and adolescent mental health services, much attention was given to training provider staff on new services such as therapeutic foster care and wrap-around services. Additionally, the state conducted a "Best Practices" training conference for system provider staff from throughout the state, to introduce best practice concepts for mental health, developmental disability and addictive disease services. With the governance changes within DMHDDAD that occurred, training of provider staff diminished.

Over the past few years, provider staff has indicated a need for DMHDDAD to resume training staff in new service models and interventions. In particular, with the closure of the child and adolescent hospital beds, community staff expressed a need to receive intensive training on delivery of crisis services. To that end, DMHDDAD identified funding to support a two-year initiative that provided a series of training events and on-site technical assistance on delivery of crisis services. The child and adolescent mental health providers in all seven regions received specialized crisis intervention training and technical assistance. Through a contract with the Technical Assistance Collaborative, Inc. (TAC), the goal was to develop and deliver specific training related to crisis intervention services. The training events included a one-day conference to help providers and line staff develop appropriate competencies for the delivery of crisis intervention services. Three training events were then held for line and supervisory staff on risk assessment, developing crisis plans, and suggested best practices for crisis services delivery. In addition, forty hours of on-site technical assistance was provided to providers who requested assistance with development or improvement of their crisis services operational plans. Following the completion of the crisis intervention service training and technical assistance

events, the DMHDDAD developed additional training and technical assistance for providers through the contract with TAC to address development and enhancement of existing crisis residential services for youth with SED. Providers from all seven regions participated in a one day training event that highlighted two model programs from other states (Maine and Kentucky). Following the one-day training, three technical assistance groups were held for providers in various parts of the state who were interested in enhancing current crisis residential programs or want to develop community based crisis residential services, such as crisis group homes or crisis stabilization programs.

DMHDDAD is currently working on building systems of care throughout the state and launched a System of Care (SOC) Quality Improvement (QI) Initiative in August 2003, with buy-in from state level leadership child welfare and juvenile justice agencies. DMHDDAD contracted with Sheila Pires of the Human Service Collaborative in Washington, D.C., a well-known expert on Building Systems of Care to lead this yearlong Quality Improvement Initiative. This initiative is discussed in greater detail in Criterion Three.

Plans for the Future

DMHDDAD will continue to focus on strategies to improve and expand community-based mental health services to youth with SED and their families. The information from the gaps analysis, the work of the Mental Health Task Force and the continuation to implement the strategic action plans developed in the System of Care Quality Improvement Initiative will help DMHDDAD determine the next steps needed to move toward a full continuum of care for youth with SED and their families.

In addition, Georgia is planning to implement a “fee for service” system to replace the performance contracting that has been utilized in the past. Rather than contracting with providers for set funding amounts based on historical service capacity, providers will be paid for units of service provided to individual consumers. This will put services funded with state grant-in-aid on the same footing as those funded by Medicaid. To accomplish this initiative it will be necessary for the External Review Organization (ERO) to monitor service utilization and appropriateness for non-Medicaid eligible consumers as well as those who are served by Medicaid.

To improve service entry and linkage, the state is also planning to implement a statewide call center to perform the Single Point of Entry services. This function has varied by region in the past, creating inconsistencies within the system from region to region. With the mobility of consumers and their tendency to move from place to place, understanding the system for service entry and linkage in a different location presented significant challenges. This change will ensure that individuals throughout the system will know how to access services regardless of where they live.

DMHDDAD also anticipates development of a Core Customer definition for child and adolescent mental health services. With the development and implementation of this definition (described in Criterion 2), the system plans to implement a new eligibility process. Planning is

currently underway to develop the definition, eligibility guidelines and financial and income criteria that will be utilized in determining a fee structure and consumer co-pay schedule.

CRITERION 2: Mental Health System Data Epidemiology

Strengths, Challenges and Gaps of the Mental Health System Data Epidemiology

DMHDDAD provides services to youth with SED and their families. Georgia has been using the federal definition of SED as part of the eligibility criteria for services along with criteria to determine if the youth and family is most in need. Youth with SED are under age 18 and have a diagnosable mental, behavioral, or emotional disorder. The disorder meets diagnostic criteria specified in the DSM IV. The disorder is of sufficient duration that has resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities. The definition of most in need is as follows:

Consumers who are “**Most in Need** “ of services are those with social, emotional, developmental, or physical disabilities resulting from mental illness, mental retardation, autism or substance abuse who without State-supported services are unable to function. This group includes consumers who have a long history of dysfunction, consumers whose history and clinical status suggest a long-term course of service and consumers and their families with temporary but urgent need for intervention. The contractor will deliver services to individuals who meet the following disability/diagnostic criteria:

a. **Disability:** The individual demonstrates:

1. Behavior leading to public demand for intervention; or
2. Substantial risk of harm to self or others; or
3. Substantial inability to demonstrate community living skills at an age-appropriate level; or
4. Substantial need for supports to augment or replace insufficient or unavailable natural resources

AND

b. **Diagnosis: Individual meets the following diagnostic criteria as determined by a professional licensed to do so:**

1. Adults with mental illness, excluding personality disorders and V-Codes; or
2. Children and adolescents with severe emotional disturbance, including those displaying signs of such disorders; or
3. People with mental retardation; or
4. Children and adolescents with dependence on alcohol or other drugs, and those displaying signs of such disorders; or
5. Adults with dependence on alcohol or other drugs; or

6. People with autism.

Estimation methodologies recommended for youth with SED were provided by the Center for Mental Health Services. These estimation methodologies identified two prevalence estimates, one of 5% - 9% for youth with SED and extreme functional impairment and one of 9%-13% for youth with SED with substantial functional impairment. These estimates are only applied to the 9-17 year old age group. No estimation methodology has been provided for estimating prevalence of emotional disturbance in children birth through age 9. According to the Uniform Reporting System Tables provided by CMHS, Georgia would utilize the 6%-8% range for determining prevalence of youth with SED and extreme functional impairment and 10%-12% range for determining prevalence of youth with SED and substantial functional impairment. Applying this percentage to the child and adolescent population of 1,144,523 age 9-17 years old would yield a prevalence range of 68,671 to 91,562 for youth with SED and extreme impairment and a prevalence range of 114,452 to 137,343 for youth with SED and substantial impairment. Due to limited resources, Georgia has used the upper range of prevalence for the group of youth with SED and extreme impairment. Utilizing this figure of 91,562 as a target, it is important to note that DMHDDAD served just over 30,000 youth with SED age 9-17 in state fiscal year 2004. In addition, DMHDDAD served another 11,000 youth under the age of nine. DMHDDAD does recognize, however, that not all youth with SED in need of treatment are served by the public sector and may be served by other child-serving agencies and through the private sector.

One of the biggest challenges to the state's ability to estimate incidence and prevalence of serious mental illness and to set quantitative targets to be achieved in implementing the comprehensive system of care is the ability to gather and report accurate data. MHDDAD's existing information system does not have the capacity to collect encounter data, making it difficult to accurately determine numbers served. The state Management Information System (MIS) system only captures enrollment data, and if providers fail to release an individual from services upon completion, it will appear that the individual is continuing to receive services. It is also difficult to gather data or do data matching across systems, such as with child welfare or juvenile justice to identify individuals served by these systems or jointly with our system.

The state MIS system is also not able to capture information on consumers who have co-occurring mental illness and addictive disease, or any other co-occurring illnesses. The system only allows for one primary diagnosis for each individual, which is often changed when an individual enrolls in a different service. The only way the MIS system can identify individuals with co-occurring disorders is to sort the data by consumer unique identifier to determine if someone with a primary MH diagnosis later enrolls in an addictive disease service, or vice versa. This process produces an unrealistically low estimate of the prevalence of co-occurring disorders among the individuals served by the system.

A strength of the Georgia system related to data reporting is the Medicaid ERO. The current ERO contractor has established the capacity for "web-based" reporting of Medicaid service data. This system provides the state with encounter data for the Medicaid population that can be used to generate estimates for system level service needs and trends. The information collected about consumers served including diagnosis, functioning, and frequency of service can be reported in

many ways. These reports enable system managers to study service trends and other factors by individual consumer, diagnostic grouping, provider agency, region, state or several other criteria. In addition, the ERO provides technical assistance to provider agencies to help them improve their reporting and to utilize the information that is gathered to do quality improvement and to identify service needs.

The PERMES program for system evaluation represents another strength in the area of data collection and utilization. Georgia's consumer-to-consumer survey is one of the largest in the country and produces useful information about the quality and accessibility of the service system. In addition to the survey data collected by PERMES, providers are required to administer and report functional assessment information on each individual served. In Georgia, the Child and Adolescent Functional Assessment Scale (CAFAS) is used by all providers to assess level of functioning at enrollment and functioning after services have been provided. The data from these instruments is used to report and evaluate outcomes of treatment for consumers served.

State Priorities and Plans to Address Unmet Service Gaps/Need

To improve access to services DMHDDAD is in the process of defining its core customers for state funded mental health and addictive disease services for children and adolescents. This was a recommendation of the Stakeholders Group for Improving Service Entry and Linkage. To seek broad input into the development of the Core Customer definition, DMHDDAD held an initial meeting with stakeholders including public and private child and adolescent mental health and substance abuse providers, child welfare and juvenile justice representatives and family support and advocacy organizations to review a draft concept paper and to gain broad stakeholder input. The draft concept paper outlines diagnostic, functional and financial criteria. The levels of service proposed that would require these considerations include screening and referral, early intervention and stabilization and on-going treatment and family support. Next steps include incorporating information provided at the initial stakeholder meeting and holding a follow-up meeting with a broader group of stakeholders along with wide dissemination of the Core Customer definition. DMHDDAD anticipates that this Core Customer definition will be finalized by December 2004 and implemented by January 2005.

While the austerity of the last few fiscal years has delayed obtaining new information systems, funds have recently been identified to allow DMHDDAD to begin that process. In the meanwhile, DMHDDAD is utilizing the Data Infrastructure Grant (DIG) to develop the capacity to collect the data necessary to meet the block grant data reporting requirements. The new DIG is planned to create a data warehouse that will enhance the state's ability to receive and utilize information from other systems. With data from systems such as DJJ or DFCS, comparisons can be run to identify MHDDAD consumers involved with juvenile justice or child welfare.

Plans for the Future

Because of state procurement requirements, it will be necessary for the state to re-bid the ERO contract during state fiscal year 2005. Plans are underway to define the scope of work to be

performed by the new vendor that will be included in a new Request for Proposals. The anticipated procurement release for bids is the first quarter of FY 2005, with an expected start date of January 2006.

CRITERION 3: Children's Services

Strengths, Challenges and Gaps of the Mental Health System Data Epidemiology

The Department of Human Resources is an umbrella organization that consists of several Divisions and Offices that include DMHDDAD, the Division of Family and Children's Services and the Division of Public Health. The Department of Juvenile Justice, the Department of Community Health/Division of Medical Assistance and the Department of Education are separate agencies. DMHDDAD is the responsible agency for mental health and addictive disease services. Criterion One explains the role and organization of DMHDDAD along with services provided by the other Divisions and Departments. Georgia does not have one agency responsible for all children's services. All agencies must work together to provide a system of care for children and youth with SED.

DMHDDAD staff are members of the State Treatment and Assessment Committee (STAC) for Level of Care, formerly the Multi-agency Team for Children (MATCH). The Committee has representation from the state Departments of Juvenile Justice, Education and the Division of Family and Children's Services. All requests for out of home residential treatment are sent to this committee from over 102 local committees composed of the same representation in addition to other stakeholders such as juvenile courts, vocational rehabilitation services, and provider agencies including those under contract with Regional MHDDAD Offices. A child may be referred to one of these committees by a case manager from the lead agency providing services to the child and family. A staffing is held to better coordinate local services or to determine if local resources have been utilized to the fullest extent possible. State funding for residential treatment is a last resort for children and adolescents with SED, to be utilized only when all other efforts to help them in their communities have been exhausted. These local committees must attest that all possible local resources have been exhausted prior to sending a request for out of home residential treatment. The STAC reviews the information and makes a determination whether to make placement recommendations or send back to the community with recommendations for exploration of alternative community-based mental health resources. Funding for youth in parental custody and in the custody of child welfare is provided by DHR for residential treatment services.

Prior approvals and utilization review for the program are made by the STAC. Currently, every six month's there is a review of the youth's placement progress and progress towards reunification with their home and/or community. The STAC members, local case managers, and providers are involved in this process. Additionally, the referring mental health agency is encouraged to participate in these reviews and discharge planning in order to ensure a smooth transition back to community services.

Youth committed to DJJ are funded for placement with DJJ specialized treatment dollars. Although the funding is not pooled for DHR and DJJ, DJJ participates in the STAC process both locally and at the state level use the same policies, criteria and utilization management process. In addition, when a youth is in the custody of child welfare and committed to DJJ, the two agencies share the costs of placement. DOE also participates in the STAC process locally and at the state level although the agency does not blend funding with DHR and DJJ. DOE and Local Education Agencies (LEA) have funding to purchase residential services for youth whose emotional disturbance interferes with their education to the extent that the LEA is unable to provide appropriate educational and related services.

In fiscal year 2003, a protocol was developed to address planning for youth aging out of residential treatment. This protocol, developed in conjunction with mental health, child welfare, juvenile justice, vocational rehabilitation service, education and other stakeholders outlines roles and responsibilities of all these parties as well as providers of care in discharge planning for youth who are aging out of residential treatment. In this protocol, the Child and Adolescent MH/AD Specialist in the Regional MHDDAD Office is identified as the “facilitator” of planning and is responsible for bringing together all agencies and interested parties to begin planning at age 17 for the youth’s return to their home communities or identified community of choice. DMHDDAD institutionalized this protocol by developing a policy related to this responsibility. These staff are notified by the STAC when a youth is 17 to initiate the planning process. Simultaneously, the STAC notifies the provider of the Regional contact for discharge planning to begin.

The Governor’s Action Group for Safe Children, formed in 2002, issued recommendations for system improvements in service delivery design and organizational structure for Children. This task force consisted of top-level state agency representatives and other key stakeholders such as Juvenile Court Judges, providers and advocates. The Director of DMHDDAD was an official member of the group in addition to the Child and Adolescent Mental Health Program Chief and her staff who served as resources to this task force. Although the group’s charge was to focus on youth in out of home placements, the group recommended a need for a more comprehensive behavioral health system to serve all youth. The group recognized that the current system involves multiple systems with differing mandates, missions, funding, strategic visions and information systems.

Georgia’s child welfare agency, DFCS, like many other state child welfare agencies did not fare well in the Federal Child Welfare Reviews. The area of noted concern is the area of child safety and well-being particularly as it relates to access to mental health and physical health services. Noted in the review was that many youth identified as needing mental health services and other health services were not linked to these services. The Division’s Child and Adolescent Mental Health Program Chief has been involved with development of the Program Improvement Plan (PIP) in response to the federal reviews. This is an on-going process with the plan goals, objectives and progress reviewed periodically.

In fiscal year 2004, Georgia applied for the Comprehensive Systems Change Initiative funded by the National Center for Mental Health and Juvenile Justice. Georgia was one of three states

selected. The focus of this initiative has been to gain more collaboration between the juvenile justice system and mental health system with the ultimate outcome of diverting youth from further penetration into the juvenile justice system. A state level project team was appointed with representatives from the Governor's Office of Planning and Budget, the state offices for DJJ and DHR including child welfare and mental health, as well as private providers, juvenile court judges, advocacy organizations and other stakeholders. This stakeholder group made a decision to develop four pilot programs to test various strategies for service delivery and system improvements. With Juvenile Court Judges assuming the lead role, representatives from mental health and juvenile justice in these pilot areas have developed interagency agreements, developed uniform screening and assessment processes and are exploring use of evidence-based practices such as Multi-Systemic Therapy and Functional Family Therapy.

In response to specific concerns regarding access to mental health services raised during the Governor's Safe Action Group for Children deliberations, the DFCS Federal Child Welfare Reviews, the Comprehensive Systems Change Initiative, DMHDDAD decided to launch a Quality Improvement Initiative in fiscal year 2004 to address concerns about a need for further development and improvement of child and adolescent mental health services. This initiative, the System of Care Quality Improvement (SOC QI), began in August 2003 with buy in from state level leadership from child welfare and juvenile justice agencies. DMHDDAD contracted with Sheila Pires of the Human Service Collaborative in Washington, D.C. and well-known expert on Building Systems of Care to lead this yearlong initiative. During the first part of the initiative, DMHDDAD arranged for training and technical assistance to be delivered in each of the seven MHDDAD regions by Ms. Pires. The purpose of these initial two-day sessions was for each region to invite key stakeholders in their respective regions to participate in creating strategic action plans in order to improve services to youth with SED and their families. The stakeholders invited included representatives from DFCS, DJJ, Education, Public Health, Juvenile Court, Vocational Rehabilitation, National Alliance for the Mentally Ill (NAMI), families, consumers as well as providers of mental health and substance abuse community and hospital services. During the working sessions, the stakeholders identified strengths and challenges in their respective regions and developed extensive action plans with goals and timelines outlining individual responsibilities for each goal. The planning process included an examination of the current fragmented behavioral health services system for youth and their families that cross multiple agencies. Stakeholders in the regions have continued to meet to implement their local action plans developed through this initiative. As these collaborative meetings have occurred, areas needing state level attention have been identified. Ms. Pires was available on an on-going basis to each region for follow-up consultation and one-day follow up sessions to assess the status of implementation of the action plans and to discuss barriers and problem resolution to them. The follow up sessions were completed in July 2004. The SOC QI Initiative has provided the impetus and foundation for identifying needed service and system improvements and for initiating strategic planning to strengthen the infrastructure in the seven MHDDAD regions. Several crosscutting issues have emerged from the regional strategic planning sessions that need to be addressed by the state level. This is discussed in more detail later in this section.

The Metropolitan Regional MHDDAD Office has contracts with several Community Service Boards and Provider Networks that are engaged in various stages of system of care development. The CHAMPS Network in Fulton County is nationally known for its System of Care. This network includes an array of service providers, both public and private that can provide a full range of services. A hallmark of this system of care is the individualized treatment planning utilizing wrap-around approaches and child and family centered services. Additionally, the Georgia Parent Support Network, the Georgia Chapter for the Federation of Families for Children's Mental Health, plays a key role in service delivery and planning for youth in the CHAMPS Network. Peachstate Wraparound Initiative (aka, Kidsnet Rockdale) is the Center for Mental Health Services grantee for the Child Mental Health Initiative. This program is in its fourth year of implementation and demonstrates use of a system of care model in a suburban area of the state. A Policy Council consisting of representatives from all child-serving agencies as well as family members and youth oversees the project. The Child and Adolescent Mental Health Program Chief of DMHDDAD is a standing member of the Policy Council and has supported integration of this project with other initiatives in the Metropolitan area. The Child and Adolescent Mental Health Program Chief is also a standing member of the DeKalb Policy Council for Children's Behavioral Health. The DeKalb Policy Council formed in fiscal year 2003 to address the needs of youth in DeKalb County utilizing an interagency planning and service delivery approach. Through the efforts and oversight of the Policy Council, services for youth have been expanded to include out stationing of staff to the Juvenile Court, Schools, and child welfare offices. In addition, the Policy Council has been successful in developing a family organization to advise the Policy Council. The DeKalb Policy Council applied for and was selected to attend the Juvenile Justice Policy Academy recently held in Washington, D.C. The Cobb/Douglas CSB is also involved with local collaboratives and has provided staff to Juvenile Courts as part of planning done through the Juvenile Justice/Mental Health initiative in Georgia.

Another initiative, one that the North Regional MHDDAD Office has been involved in, is the Interagency Case Management System Pilot Project. With public health as the lead agency, collaborating partners in this initiative include juvenile justice, child welfare, mental health, education and other community-based organizations. Formal memorandums of agreement between these agencies have been developed which address the roles and responsibilities for continuity of care and provision of needed mental health and physical health services. New District and state partnerships have formed which resulted in development of formalized memorandums of agreement. District and county level staff from the partner agencies have been trained on the project, the case management model and procedures, utilization of projects forms, confidentiality and HIPAA guidelines and services provided by each of the participating partners. This pilot has been implemented with in-kind contributions of the partner agencies.

DHR and DJJ have recently implemented a Level of Care (LOC) System for purchasing out of home placement for youth. The STAC process has been integrated with this new process. LOC includes all out of home residential care, from basic group home care and therapeutic foster care to intensive residential treatment services. Youth referred for out of home care will be leveled utilizing a standardized instrument and referred to providers who have been approved to provide services to these youth according to their level. Providers of services are paid a rate according to the level of the child. Because services are to be provided to the youth based on their level of

treatment need, providers must either be able to provide step-down services or the youth must be moved to another provider who provides a lower level of care. Provider development for lower levels of care has been identified as an area of concern. Additionally, the utilization review process is key to ensuring appropriate levels of treatment. A challenge of this new system is to develop a more efficient process that addresses this issue and affords opportunity for more frequent review at the higher levels of care.

With the implementation of LOC, DMHDDAD has been given the responsibility for managing the LOC process and utilization review for youth in parental custody who are referred by mental health case managers of Regional MHDDAD providers. Currently, over 25% of the youth in residential treatment are parental custody youth. DMHDDAD will assume fiscal and administrative responsibility for these youth during FY2005. A challenge for DMHDDAD will be to develop a process that makes more efficient use of the resources while at the same time examining ways to creatively utilize the funding to offer more step-down and community-based mental health services alternatives to out of home care.

DHR and DJJ have completed the process of provider approval and contract development for FY2005. Many of the providers under contract with Regional MHDDAD Offices are also providers under the new LOC system. Youth served through LOC in higher levels of care who are Medicaid eligible have a portion of the residential treatment paid for by Medicaid under the Therapeutic Residential Intervention Services option of the State Medicaid Plan. Youth served through LOC in the lower levels of care can access mental health treatment through the Medicaid psychology program or the Medicaid Rehabilitation Option. Many of the providers under contract with Regional MHDDAD Offices are Medicaid Rehabilitation Option providers under the state Medicaid Plan. Much work is in progress to assure that duplication of billing does not occur between the two Medicaid options when serving youth through LOC.

Although the Transition Protocol has been developed to address roles and responsibilities for agencies in planning for youth aging out of residential treatment, there still remains a scarcity of appropriate and available services for this population of youth. Providers of services to youth with SED have struggled to provide appropriate transition and aftercare services. Most adult mental health services are utilized by older adults with serious and persistent mental illness. Few services exist that address the special needs of young adults ages 18-21, many of whom lack basic life and job skills. Many of these young people are at risk of homelessness or incarceration. By tracking the numbers of youth referred for transition planning and tracking progress with implementation of transition plans, DMHDDAD will be able to better identify gaps in services needed for this age group. A challenge is the overwhelming amount of work involvement that "facilitating" the protocol adds to the workload of the Regional Office MHDDAD staff. Regional MHDDAD are finding it challenging due to the high number of youth referred who are in need of transitional planning. These staff have additional responsibilities such as provider development and monitoring and evaluating service delivery.

Analysis of Unmet Service Gaps/Needs and Related Data Source

The SOC QI Initiative has provided the impetus and foundation for identifying needed service and system improvements and for initiating strategic planning to strengthen the infrastructure in the seven MHDDAD regions. Several crosscutting issues have emerged from the regional strategic planning sessions that need to be addressed by the state level. The major actions identified as key to infrastructure improvement are as follows:

- Need for a statewide vision for behavioral health services that cuts across all of the major child-serving systems
- Need for expansion of family and youth partnerships throughout the state
- Need for a cross-system workforce development and training agenda
- Need for development of a methodology for expanded information sharing
- Need for financial mapping of current fiscal resources across all child-serving systems supporting service delivery
- Need for methodology for re-directing resources from higher intensity services to more community-based services
- Need for policy and practice development to address barriers posed by current design of Medicaid Rehabilitation Option services
- Need for promotion of and development of culturally competent providers
- Need for increased home and community-based service capacity
- Need for development of additional substance abuse treatment services and development of specialty services to address youth with co-occurring disorders
- Need for development of evidenced-based practices and practice based evidence services
- Need to link related service system reforms, organize provider networks and address privacy issues

State Priorities and Plans to Address Unmet Service Gaps/Needs

DMHDDAD will continue to work with other partners in implementation of the LOC while at the same time exploring ways to increase the focus on developing integrated community-based systems of care. DMHDDAD will continue to work with Regional MHDDAD Offices and their stakeholders on implementation of the strategic action plans developed from the System of Care Quality Improvement Initiative. DMHDDAD will meet with and follow the progress of the Regional SOC Action Teams. In addition, DMHDDAD child and adolescent mental health staff will address the cross-cutting issues identified with the Division Management Team in order to move discussion of these issues to the Department level with resulting action. DMHDDAD is committed to better serving youth involved with juvenile justice and child welfare and will continue through LOC implementation, through the SOC QI Initiative and through the Transition Protocol to better serve these youth. Additionally, DMHDDAD will continue to track improvement in functioning in school as an indicator that youth are receiving more integrated service delivery to help them remain in their homes when possible, schools and communities.

DMHDDAD is committed to the continued success of the Transition Protocol planning process. As of FY04, over 200 youth were identified as aging out of residential treatment services and in

need of planning through the Transition Protocol. Regional MHDDAD staff have been inundated with referrals for this planning process. Two of the seven regions have been particularly overwhelmed with referrals and facilitation of the planning process. DMHDDAD plans to work through the Regional Coordinators and with the C&A MHAD specialists to determine what resources are needed to support the successful implementation of the protocol. Additionally, it is critical that the Regional Adult MH/AD specialists and the Regional DD specialists work to assist the C&A MH/AD specialists in the facilitation and planning responsibilities. DMHDDAD will continue to track the number of referrals of youth for transitional planning and in particular begin evaluating the most critical areas of support needed for youth identified in the planning process. This information will assist DMHDDAD in future planning of needed services for this transitional age group. It is also anticipated that the Gaps Analysis Project previously mentioned will inform the DMHDDAD of the service needs for this population of youth.

Recent Achievements and Plans for the Future

Georgia has applied for a Child and Adolescent State Infrastructure Grant (C&A SIG) from SAMHSA to help expand the state's infrastructure for developing comprehensive systems of care to meet the needs of youth with SED, substance abuse, and co-occurring disorders and their families. Strategies in the C&A SIG include: development of a trained workforce, funding strategies, policies and practice guidelines and web resource development and improved data infrastructure development. The overall purpose of the C&A SIG is to provide the ability to strengthen the capacity, from a state level, to develop, expand and sustain mental health, substance abuse and co-occurring services and supports at the community-based level for youth who have SED, substance abuse and co-occurring disorders and their families.

DMHDDAD will be the lead agency for the project if funded. The project activities include the establishment of a State Level Children's Behavioral Health Service Collaborative (CBHS). The CBHS will develop a statewide vision for behavioral health services across all child-serving agencies, develop a state strategic plan for building capacity to provide behavioral health services including provider and network development, mapping financial resources currently being spent on behavioral health services across the child-serving systems and maximizing use of all funding streams. Achievement of these activities will lead to an improved service delivery system for youth and their families.

All of the activities proposed in the C&A SIG were based on the crosscutting issues identified through the System of Care Quality Improvement Initiative. If DMHDDAD is not awarded the grant, the agency will continue to work on the crosscutting issues through the regional SOC Action Teams and through leadership at DHR.

CRITERION 4: Targeted Services to Rural and Homeless Populations

Strengths, Challenges and Gaps of the Mental Health System Data Epidemiology

Rural is defined as those counties not included in Metropolitan Statistical Areas (MSA). Six of the seven MHDDAD regions have rural areas within the region, and one of those is entirely rural. As such, service to persons living in rural localities is of primary concern to Georgia. Mental health service planning for rural areas occurs at a local level through the regional office. Regional MHDDAD Offices through input from their Regional Planning Boards, public forums, public surveys, focus groups, and youth and family satisfaction surveys, are able to gather information to better plan for services in all areas of the state, particularly with rural areas.

Increasing access to services has been a major thrust of the DMHDDAD and its Regional Offices. Regional Offices through the contracting process encourage providers to deliver services out of the clinic setting. Although services for children and adolescents have been delivered outside of the clinic since the early nineties, implementation of the Medicaid Rehabilitation Option has allowed for a broader array of service options to be delivered in homes and other locations. Many providers have extended service hours on weekdays and weekends as well. Access to services in rural areas is addressed through the expansion of services to satellite centers in smaller communities. Some providers also outstation staff to juvenile courts, child welfare offices and schools to make services more accessible to youth and their families. Transportation is also provided for many youth involved with activity therapy, day supports and day treatment.

Three of the new services implemented in the Rehabilitation Option are Intensive Family Intervention (IFI), Community Support Team (CST), and Community Support Individual (CSI). These services can be delivered in any setting and as a result are delivered in closer proximity to the youth and based on the individual needs of the youth and their families. The traditional model of (IFI), with a strong team identity for services, is tested heavily in rural areas in which staff travel long distances to see consumers. A healthcare professional shortage in rural areas of the state also affects the ability to develop service capacity for IFI due to the need for a higher level of professional and credentialed staff. Less intensive levels of mobile service like CST and CSI have proven to be easier to implement in rural settings. The issue of travel is still a challenge for mobile community support teams operating in rural areas. The challenge is to implement these model approaches to service in cost efficient ways and also promote access to services for all consumers in need.

Many youth with SED have runaway behaviors, families with economic pressures and poverty, poor familial relationships, substance abuse and/or family substance abuse, violence, physical, sexual and emotional abuse and neglect within the family. Many youth with SED also have the “throw away” experience in which parents or caretakers tell them to leave the home or do not receive support when the youth are placed outside the home and parents are reluctant to have them return to their homes. These risk factors can increase the chances for homelessness for the family and/or the youth with SED. Youth who are in state custody through the child welfare

system often do not have safe family members who are involved with them and they often times end up in emergency shelters, child protective custody or foster care. Many of these youth grow up in the child welfare system and age out at the age of eighteen only to sign themselves back into care for access to Independent Living Programs, funded through DFCS. The DMHDDAD provides Prevention and Early Intervention programs in Georgia that include SAMHSA's Prevention strategies to reduce the incidence of homelessness. The programs identify both the risk and protective factors for homelessness and preventative interventions that could be used to identify and prevent homelessness among youth at risk. The programs also identify and promote the use of effective, evidence-based homelessness prevention interventions, ranging from family strengthening and high-risk youth programs to specific interventions such as discharge planning and crisis intervention. Youth with SED fall into the Selective Prevention category, as established by the Institute of Medicine (IOM). The SED population is a specific targeted subgroup of the population whose risk for homelessness is significantly higher than average.

The DMHDDAD will continue to fund prevention, early intervention and mental health treatment services to identify youth with SED and their families who are at risk for homelessness and ensure that appropriate interventions are provided to meet the needs of this high risk target population in Georgia. Comprehensive mental health services are available in all regions for children and adolescents with SED who are homeless. These homeless youth have priority for state services by being identified as those who are most in need. Current efforts related to homeless youth with SED are efforts to increase outreach and service delivery. DMHDDAD in previous years required Regional Offices to include data on numbers of homeless youth with SED served by their providers. Due to not having a uniform definition of homelessness at that time, the data reported was inconsistent and deemed to be not very accurate or informative. As a result, homeless data tracking has been included in Georgia's performance measurement and evaluation system (PERMES) to identify those persons who experienced an episode of homelessness within the past year with subsequent follow-up assessments to measure quality of life, functioning level, satisfaction, and service availability and access. These data tracking efforts provide information necessary to improve service access and resource supports for youth with SED who are homeless. Providers are now required to gather information on living situation upon enrollment in services. Some child and adolescent mental health providers have been actively serving youth in child welfare emergency shelters as well as in Women's and Children Homeless shelters. Up to this time, there has not been mechanisms to determine how many youth served were also homeless which has been a challenge for DMHDDAD. Having the ability to now collect data on living situation will provide DMHDDAD with information on the scope of the problem as well as the areas where more attention is needed.

A major strength for DMHDDAD is the work being done to address the needs of transitional youth, those youth turning 18 years old who are in need of services. This group of youth with SED often drops out of services, become homeless and/or become involved with the criminal justice system. The Department of Human Resources (DHR), in collaboration with the Georgia Department of Community Affairs (DCA) has initiated an opportunity for mental health consumers to utilize low-income, Section 8, community-housing vouchers. This collaboration will facilitate the acquisition of affordable rental residences and promote community reintegration as part of the Olmstead Plan for Georgia. As part of the strategic planning in the

development of this program, the DMHDDAD has determined the formulation of a plan that will assist transitioning consumers from regional hospitals, other residential treatment facilities and other community agency settings. One of the three target population groups includes Transitional Youth and there have been thirty-one vouchers earmarked for these youth in three different counties in the state. The Transitional Youth will be identified from the Level of Care (LOC) program and will be those who are aging out of the LOC program when they turn eighteen and may also include youth from other community agency settings who are in need of independent living situations and qualify for the voucher initiative. Training and technical assistance on this voucher initiative, including the application process will be scheduled with individual regions by DHR and DCH staff during FY 2005.

Analysis of Unmet Service Gaps/Needs and Related Data Source

In FY 2005, DHR plans to conduct a mental health services gaps analysis by collecting and analyzing data that will be used to demonstrate mental health service needs for individuals of all age groups residing in Georgia and compare that information with the mental health system service capacity and utilization to determine the level of unmet need. The gaps analysis will specifically address issues related to serving the homeless population and those living in rural areas.

In 2001, an analysis by APS Healthcare, Inc. on the number of credentialed staff among community service boards in Georgia revealed some regions having far fewer available licensed staff than others, and that up to 30% of those licensed staff were administrators who performed no direct service. The one region identified as entirely rural reported the fewest number of credentialed staff at 90. This credentialed workforce shortage impacts the ability to provide those services in rural areas of the state that require credentialed staff.

State Priorities, Plans to Address Unmet Service Gaps/Needs, Plans for the Future

Greater focus will be given to the types of services delivered to children and adolescents with SED and their families who are homeless or residing in rural areas. Providers will be encouraged to increase the provision of out of clinic services such as IFI, CST and CSI, all of which can be delivered in a child's home, school and other locations. The state plan will include a goal to increase the number of youth served in rural areas utilizing these services.

The FY 2005 gap analysis of the mental health service system will help identify unique needs and gaps in services for homeless and for rural consumers. The contracted consulting group will produce a final report that will be used to guide members of the Mental Health Planning & Advisory Council in their federally mandated role of advocating for improved services during the Georgia General Assembly Session of 2005, and for the DMHDDAD use in service planning for the FY 2006 and future years planning and contracting cycles. Additionally, the information gleaned from the PERMES data collection process will assist DMHDDAD in determining the scope of the problem with homeless youth and lead to a more informed planning effort. A state plan will include a goal to increase the number of youth with SED served who are also homeless.

In December 2002, the City of Atlanta Homeless Commission was formed following a SAMHSA led challenge to mayors in major metropolitan cities across the nation to end homelessness. United Way of Metropolitan Atlanta lead a broad effort to analyze the issue of homelessness resulting in developing a *Blueprint to End Homelessness in Atlanta*, which includes 29 prioritized projects with seven projects identified for immediate implementation. The Commission has remained diligent in implementing this action plan and has made the top ranked initiative a 24-hour support center called Gateway. This resource will serve as the point of entry to comprehensive homeless services and will include drop-in services, health care services, and four residential programs with a total capacity of 289 to serve the mentally ill, addictive, and medically fragile populations. Part of this resource has been designated for use with transitional youth, those turning 18 who are in need of continued treatment and other support services such as housing. Gateway is anticipated to open in the winter of 2004.

CRITERION 5: Management Systems

Strengths, Challenges and Gaps of the Mental Health System Data Epidemiology

Federal mental health block grant funds in the amount of \$6,985,455 and State funding of \$38,070,059 are being allocated to regions for state FY 2005 for community services for children and adolescents with SED and their families. An additional \$3,162,848 is budgeted for community initiatives through DMHDDAD for child and adolescent mental health services. Regional offices will select providers, contract for services and monitor service outcomes in community mental health service areas. Funds will be used for service priorities identified by regional planning boards as well as for statewide priorities. Regions are encouraged to utilize block grant funds for new and innovative services for which there may not be another source of funding. Tables showing the provider agencies contracted by regions for services utilizing block grant funding in FY 2004 as well as the agencies with which regions will contract utilizing block grant funding in FY 2005 are included in Section III, Criterion 5 of this document. Services provided by each agency using block grant funds are also indicated on the tables. It is expected that similar expenditures will occur in FY 2006 and FY 2007, but tables for those years will be updated in the applications for each year.

The total funding allocated for child and adolescent community mental health services is \$48,218,362. This funding was made available over the past 14 years though new appropriations, redirection of funding from closure of hospital beds and through increases in the Mental Health Block Grant. Based on a multi-year state strategic plan, the first phase of planned expansions was completed in state fiscal year 1999 consisting of additional outpatient services, in-home crisis services, day treatment, respite care, therapeutic foster care and therapeutic group home care services. Since the completion of Phase I, over \$8 million has been made available for the expansion of respite care, day treatment, in-home services, case management and wraparound services and for the development of mobile crisis services and crisis residential services, intensive family intervention services, and transition homes for adolescents exiting intensive residential treatment. Fiscal year 2004 was the first year that additional funding was not made available for expansion of child and adolescent mental health services. In addition,

community-based funding for child and adolescent mental health services has been reduced by over a million dollars for fiscal year 2005. DMHDDAD will continue to explore financing strategies to continue to move the development of child and adolescent mental health services forward. Although much has been gained in resources, child and adolescent services remain under funded.

During the 2001 session of the Georgia General Assembly, the decision was made to apply for a change in the state Medicaid plan, moving from services provided under a Clinic Option to services provided under a Rehabilitation Option. The governor and members of the General Assembly determined that this change would enable the state to take fuller advantage of federal resources available under the Medicaid program, making state dollars available to implement new programs of service. This change became effective with the state's fiscal year 2002, which began on July 1, 2001. This change has allowed the state to offer an expanded array of services in settings other than mental health centers, greatly enhancing the scope and focus of the service system. With this shift, the DMHDDAD also received the Medicaid "State Match" dollars in its budget, and for the first time became "at-risk" for managing the utilization of Medicaid mental health services.

Since July 1, 1999, DHR, in partnership with the regions, has contracted with a single, independent External Review Organization (ERO) to monitor services and assess whether people are getting the services they need from the right providers for as long as they need. The ERO ensures that the services are of high quality with effective outcomes, which support the philosophies of rehabilitation and recovery. Included in their review are factors such as staffing credentials and ratios, as required by service standards. Service requirements, including staffing expectations are established in the Provider Manual, and are the same for Medicaid and state funded services. The ERO data assists the regions and providers with service problem identification and resolution. The review organization continues to work closely with DMHDDAD and its providers to assure an effective and efficient Medicaid mental health system. This impacts the total mental health system since federal law requires that there be no distinction between Medicaid and non-Medicaid services.

All community staff providing services have credentials that satisfy DMHDDAD policy and guidelines and state licensing laws. State standards require a staff development program within each contracted community mental health program. Providers are required to have policies, plans, and practices to evaluate and improve staff competencies, including disability, age, and program specific competencies with attention to best practices and new technologies in services and supports delivery. For example, staff providing child and adolescent services must have expertise in working with children and adolescents with SED. In addition, all staff must have training in ethics and cultural competence. Standards include minimum requirements for a staff development program.

MHDDAD recognizes the critical importance of staff development and training. To that end, a training coordinator was employed to facilitate the many training and development activities that are offered through DMHDDAD. During FY 2004 over twenty training events were offered that were specific to improvement of child and adolescent mental health services and the system of

care. One of the initiatives mentioned earlier in Criterion One, focused on enhancing the skill base of providers in delivery of crisis intervention and crisis residential services. On-site technical assistance and consultation was also offered to providers as a follow-up to training received. The other major initiative was the “Building Systems of Care Initiative” mentioned in Criterion One that was provided by Sheila Pires, a national expert in building systems of care. Each region and their providers and representatives from key stakeholders such as family members, child welfare, education, juvenile justice, schools, and courts received training on developing systems of care for youth with SED and their families. In addition, Ms. Pires also provided training in 2004 to child and adolescent inpatient hospital staff, Regional Planning Board members, Regional Office administrators, regional child and adolescent mental health and addictive disease specialists and the DeKalb Policy Council for Children’s Behavioral Health Services.

DMHDDAD also sponsored training to providers of child and adolescent services on the CAFAS in July 2004. This training, provided by Dr. Kay Hodges the author of CAFAS, is given on a yearly basis and utilizes a train the trainer model approach so that the trained providers can train new staff and clinicians on administering the CAFAS. Through the PERMES project, all child and adolescent providers are required to administer the CAFAS to every consumer enrolled into services upon intake/admission, 90 days, annual review and discharge. Dr. Hodges also includes previously trained trainers in these sessions for purposes of offering a “refresher” course to avoid rater drift and ensure rater reliability in administering the CAFAS.

Other training initiatives were generated in response to gaps and challenges identified by the Medicaid ERO, in an effort to improve the clinical skills of staff in the system. Training was provided on Intensive Family Intervention services for a pool of new providers. Additional initiatives have been identified as a result of quality improvement activities. An example of a QI driven training initiative is the Sciacca training, mentioned in the adult plan, and consultation related to integrated treatment of persons with co-occurring mental and addictive disorders. A quality improvement project identified the limited ability of providers to serve such a challenging population, and resources from adult mental health as well as from addictive disease budgets were identified to launch the initiative. In the two years that this initiative has been underway, a total of 467 clinicians have participated in eleven training events. Several child and adolescent mental health clinicians have taken advantage of this training.

Recognizing the tremendous growth in ethnic minority populations in Georgia, the Mental Health Planning and Advisory Council urged the state to assess the base-line levels of cultural competency among the providers of mental health services and to determine what training could be helpful in raising those levels. Utilizing Mental Health Block Grant funds, the state contracted with Georgia State University’s Department of Anthropology to conduct an assessment of providers and to develop a plan for training of provider staff. This assessment and training initiative has been completed and has been followed by a joint initiative with the addictive disease section to further expand cultural competence training for provider staff and to develop a cultural competence strategic plan that will guide these efforts for the future.

Analysis of Unmet Service Gaps/Needs and related Data Source

The Office of the Governor commissioned a study of the Community Service Board service delivery system in 2003, and the Phase one report of the study was issued in February 2004. This report identified that Georgia ranked 43rd in mental health expenditures for 2001, based on the NASMHPD Research Institute State Profile report. The same NASMHPD report was again cited to show that Georgia's average per capita spending actually declined by 0.9% between 1990 and 2001. With growing populations seeking services from the public mental health system and static funding, the gaps in service availability can be expected to increase.

State Priorities and Plans to Address Unmet Service Gaps/Needs

As stated earlier, Georgia is preparing to contract for an independent review of service gaps that will address not only the services needed compared to what services are provided. The study will also look at system capacity and staff competencies to identify training and service improvements that are necessary. The MHPAC will use the results of the analysis to advocate for service system improvement, including necessary fiscal and staff resources. The state will utilize the information to facilitate planning for future years. Also, the SOC QI has provided much information on areas that need attention to improve the infrastructure to provide mental health and addictive disease services. The information contained in the Action Plans from the regional stakeholder meetings will help inform the information-gathering phase of the Gaps Analysis.

Recent Achievements

Due to changes in organizational and governance structures over the last 10 years, DMHDDAD had focused less attention on enhancing the skill base of providers. Child and Adolescent providers have been desperate for training and could not avail themselves of training opportunities due to limited local resources. This impacted DMHDDAD as evidenced by a problem that arose in FY2002 when funding was appropriated for crisis services. Many providers had difficulty implementing the new service due to a lack of skill base by the existing child and adolescent mental health staff. DMHDDAD identified funding to utilize in a two-year training series to focus on delivery of crisis services. This two-year project has just been completed and has greatly enhanced the skill base for child and adolescent mental health service providers leading to better delivery of crisis services to youth with SED and their families. In addition, the Division developed suggested best practices for delivery of crisis services, which have been included in the FY2005 Provider Manual. With the availability of better crisis services, youth can be diverted from hospital services and other out of home placement. The on-site technical assistance provided by the contracted consultants provided DMHDDAD with information on the areas that were improved as a result of the training and areas that still needed attention.

Plans for the Future

As mentioned previously, Georgia has applied for the C & A SIG grant to build the infrastructure of child and adolescent mental health and addictive disease services and to expand training and

capacity of providers to deliver integrated services for with SED, substance abuse disorder and co-occurring mental and substance use disorders. Whether the C&A SIG is funded or not, Georgia plans to continue with plans to improve the system of care for youth and their families through the continued efforts of SOC Action Teams in each region.

SECTION III. Performance Goals and Action Plans to Improve the Service System

ADULT PLAN

CRITERION 1: Comprehensive Community-Based Mental Health Service System

Current Activities

Georgia provides a comprehensive community based system of mental health care for adults with serious mental illness who need public services. As reflected in Section II of this document, a full array of community based mental health services is provided in each service area of the state, including evidence based practice services identified as most effective for individuals with serious mental illness. While not all services are available in every one of Georgia's 159 counties, each county is included in one of the state's 25 service areas. The full array of services is provided in the lead counties of the services areas, at a minimum, with some services available in satellite offices or through mobile service delivery. The following services for adults with mental illness are provided across the state through a combination of state, federal and Medicaid funding:

- **Screening, Crisis and Outreach Services**

- Outreach
- Diagnostic/Functional Assessment
- Crisis Intervention
- Crisis Stabilization
- Community Based Inpatient Services
- Pharmacy Services
- Consumer and Family Education
- Family Support
- Respite

- **Outpatient Services**

- Physician Assessment and Care
- Nursing Assessment and Health Services
- Medication Administration
- Assertive Community Treatment
- Individual Counseling
- Group Training/Counseling
- Family Training/Counseling
- Community Support Individual

Community Support Team

- **Day and Employment Services**
 - Psychosocial Rehabilitation
 - Peer Support
 - Intensive Day Treatment
 - Community Based Employment Services - Individual
 - Community Based Employment Services – Group – Mobile Crews
- **Personal Living and Residential Services**
 - Independent Living Supports
 - Skills Training and Supported Living
 - Structured Living Supports
 - Intensive Living Supports
 - Room and Board
- **Service Entry and Linkage** – Single point of entry to the system

For the past several years, Georgia has focused on shifting the adult mental health service system from its prior emphasis on symptom relief and maintenance to one that emphasizes recovery and the goal of “getting a life,” as articulated by members of the state consumer movement. Most evidence based practice services are currently available in the state service system, though not every service is available in every service area. Particularly limited is the availability of Assertive Community Treatment (ACT). Because many of the service areas in Georgia cover multiple counties, many of which are very rural and remote, service providers are reluctant to employ this practice and do not consider it cost effective because of the great distances that teams would be required to travel to provide services. Additionally, in the more rural areas of the state, the shortage of licensed and credentialed mental health professionals make it difficult to secure the level of clinical expertise required to comply with the model. More work is needed to increase the number of ACT providers in the system.

Supportive housing services, employment services, new generation medications and peer support services are EBPs that are available in every service area, though perhaps not in every county. Integrated services for persons with co-occurring mental illness and addictive disease are being developed and offered in many areas of the state with the support of a capacity building training and technical assistance initiative that has been underway for the past two years. At this time however, it is not possible for the state’s information system to capture accurate data on the numbers of individuals receiving such services. Likewise, there is no code to capture information on family psycho education services. Currently the state contracts with NAMI GA to offer Family-to-Family classes in many parts of the state.

Medicaid is the fund source for about half of the individuals receiving services in the Georgia system. With the move to rehab option services in 2001, more services are available in settings other than mental health clinics. Many of the provider agencies have faced challenges in learning the new service structure and in transitioning mental health staff from office settings to

more mobile service delivery. The ERO has provided technical assistance and training for provider agencies to help with this transition and to increase understanding of and compliance with the Medicaid service standards.

The state utilizes contracting requirements and performance expectations to foster implementation of the desired array of services in the system. Combined with training and technical assistance, these factors have enabled Georgia to expand the available service capacity within the state. A full discussion of the comprehensive nature of services provided in the system, as required by the statutory requirements that establish the block grant, is included in Section II of this document.

Goals, Targets and Action Plans

The goals enumerated for this criterion are long term in nature and will direct the Plan for FY 2005 through FY 2007 unless otherwise stated.

- Goal 1:** Consumers will obtain and maintain meaningful employment in integrated [community] settings. This goal relates to Recommendation 5.2 of *Achieving the Promise*, to “advance evidence based practices.”
- Indicator 1:** Mental health consumers enrolled in services for at least three months engaged in competitive employment
- Target 1:** 20% of adult mental health consumers enrolled in services for at least three months will be competitively employed in FY 2005 with a 1% increase for each year for FY 2006 and FY 2007
- Action Plan:** Regions will set targets for providers related to numbers of consumers that are assisted to obtain competitive employment. The MH/AD Housing and Employment Specialist at the MHDDAD state office will collaborate with Rehab Services to obtain current information on VR services that can be shared with regional office MH/AD Specialists. Technical assistance will be provided to provider agencies as requested. Certified Peer Specialists will continue to be trained in special skills necessary to provide supports to consumers who are working or seeking work. Increasing employment opportunities for adult mental health consumers has been a goal of the system for a number of years. The activities identified in this action plan will be on-going over all three years included in this application.
- Goal 2:** Evidence-Based practice services will be available to consumers. This goal also relates to “advancing evidence based practices” called for in Recommendation 5.2 in *Achieving the Promise*.
- Indicator 2.1:** Adults with SMI receiving Evidence-Based Practice services
- Target 2.1:** To increase the number of adults with SMI receiving EBP services by 50 each year for FY 2006 and FY 2007 over the baseline data reported for FY 2005
- Action Plan:** MHDDAD state office staff will provide information on EBP services to regional office MH/AD Specialists to assist them in providing technical

assistance to service provider agencies regarding implementation of EBPs. Statewide training will be offered to clinical staff to increase skills and program model fidelity regarding EBPs. Regions will set expectations of provider agencies for the number of persons to be served using EBPs. Service standards will be established to incorporate the practice guidelines and staffing expectations to achieve program model integrity for EBP services. Community Support workers will be encouraged to partner with consumers in developing Individual Service Plans that include EBPs as interventions for achieving individual goals. Expanding EBPs has been a long-term goal of the Georgia system. The activities cited here will be employed for all three years in this state plan.

- Indicator 2.2:** Actual Evidence-Based Practices provided in Georgia
- Target 2.2:** At least five Evidence-Based Practice services will be available statewide to adults with SMI in Georgia.
- Action Plan:** Regional offices will monitor service arrays and service availability within each region to assure that EBP services are included in the service mix. Data from the ERO and from the statewide information system will be reviewed to determine service utilization of all services. Regional MH/AD Specialists will provide technical assistance to provider agencies in EBP service standards and implementation. Expanding EBPs has been a long-term goal of the Georgia system. The activities cited here will be employed for all three years in this state plan.
- Goal 3:** Access to community services for adults with serious mental illness who are in local jails or released on probation or parole will be improved.
- Indicator 3:** Number of enrolled consumers who receive Transition and Aftercare for Probationers and Paroles (TAPP) services
- Target 3:** Increase the number of individuals receiving TAPP services by 10 per year for FY 2005, FY 2006 and FY 2007.
- Action Plan:** Regional offices will monitor TAPP service utilization to assure that linkages are being made and that consumers are gaining access to community services upon exiting jails or prisons. State office forensic staff will continue to collaborate with Department of Corrections and Pardons and Paroles staff to monitor the quality of these programs and to address challenges or barriers that may arise. It will be necessary to continue these activities throughout the three years of this state plan. Through an initiative of the Governor's office, one pilot site will be developed for the provision of mental health services specifically for individuals in jail or on probation or parole.
- Goal 4:** Decrease the number of consumers being readmitted to state hospitals within 30 and 180 days of being discharged.
- Indicator 4.1:** Percentage of persons readmitted to adult mental health unit (non-forensic) state hospital inpatient care within 30 days of discharge

Target 4.1	Reduce 30-day readmission rates by 0.5% each year for FY 2005, FY 2006 and FY 2007.
Action Plan:	State office staff will provide technical assistance to regions as requested to improve continuity of care efforts. Regional offices will enhance continuity of care efforts between hospital and community services. Greater attention will be given to assuring that individuals leaving hospitals are connected to community services upon discharge, and that discharge planning will include community input regarding service recommendations. Person Centered Planning (PCP) will be conducted for all individuals that are hospitalized longer than 60 days, to identify individual goals and all supports necessary to ensure success in community services. During FY 2005, the PCP process will be implemented throughout the system, following training and mentoring provided by a contracted consulting organization. Regions will continue to assure that PCPs are conducted as necessary for the remaining two years of this plan.
Indicator 4.2:	Percentage of persons readmitted to adult mental health unit (non-forensic) state hospital inpatient care within 180 days of discharge
Target 4.2	Reduce the 180-day readmission rates by 0.5% each year for FY 2006 and FY 2007 over the baseline established for FY 2005.
Action Plan:	Regions will establish community crisis intervention and stabilization capacity to reduce the need for individuals to return to hospitals when crises occur or symptoms increase. Certified Peer Specialists working in peer supports, ACT, CST and psychosocial rehab will work closely with consumers to develop Wellness Recovery Action Plans (WRAP) that will help individuals recognize signs of potential crises and establish actions they will take and supports that they need to avert problems leading to hospital admission. These activities will continue for all three years of this state plan.
Goal 5:	Consumers will perceive positive change as a result of services received.
Indicator 5:	Consumers reporting positively about outcomes
Target 5:	Positive response about outcomes of services will increase by 1% each year for FY 2006 and FY 2007 over the baseline reported for FY 2005.
Action Plan:	Georgia will continue to survey consumers using the eight MHSIP questions for perception of outcomes to determine percentage of positive response. Using a number of questions allows consumers to consider many factors involved with outcomes and to recognize positive change in their lives. CPS staff in all services, but especially in peer supports, will work with consumers to focus on their WRAP plans and help them learn to recognize and articulate the progress they are making toward their goals. During service utilization reviews and reauthorizations, provider staff will review goals and progress with consumers to help them to recognize progress they have made and identify actions they can take to

benefit more fully from the treatment interventions. These activities will continue throughout the three years covered by this state plan.

CRITERION 2: Mental Health Systems Data Epidemiology

Current Activities

Georgia's plans for system capacity and service development to meet adult mental health needs are based on federal estimates of prevalence of serious mental illness in the population aged 18 and older. Prevalence tables are constructed annually for each MHDDAD region based on county population figures for each county in the region. Regional offices and regional planning boards use these tables, as well as poverty estimates, to determine the number of individuals in the region that could be expected to require public adult mental health services.

Beginning with state FY 2005, a new adult "Core Customer" definition is being implemented to better identify those who are eligible to receive public sector mental health services. This new definition incorporates the elements of the federal definition for SMI and also sets diagnostic and functional criteria to identify eligibility for brief intervention for individuals who do not necessarily meet the SMI definition.

Data to support planning and to monitor service effectiveness is collected through several processes. The contracted Medicaid ERO collects and reports consumer encounter data that includes information on consumer level of need and response to treatment. This information is currently generated for all Medicaid eligible consumers, which represents approximately half of the adults served in the public mental health system.

System evaluation information continues to be collected through the PERMES system. Both consumer surveys and clinical functional assessment information is utilized in system evaluation. The consumer survey that is employed is administered consumer-to-consumer and utilizes the questions of the national MHSIP survey. All adult mental health consumers are assessed using the Daily Living Activities (DLA) scale at admission, after being in services for 90 days and annually to determine functional improvement.

The statewide information system provides enrollment data for all consumers enrolled in the system. Because the MHIS system uses unique identifiers for each individual enrolled in the system, data can be unduplicated for reporting purposes. This system has several flaws that inhibit the division's ability to capture all the information that is desired for planning and reporting purposes, but the state's participation in the CMHS Data Infrastructure Grant is providing support in developing systems that will improve decision-making and service delivery.

Goals, Targets and Action Plans

The goals enumerated for this criterion are long term in nature and will direct the

Plan for FY 2005 through FY 2007 unless otherwise stated.

Goal 1:	Increase accessibility of public mental health services.
Indicator 1:	Percentage of enrolled consumers who rate access to and availability of mental health services positively
Target 1:	Positive rating of access to services will increase by 1% per year for FY 2005, FY 2006 and FY 2007.
Action Plan:	Georgia will continue to survey consumers using the six MHSIP questions for perception of access to determine percentage of positive response. Using a number of questions allows consumers to consider many factors involved with access that are then combined to comprise overall response. Service access will be increased through increased utilization of out-of-clinic services and through expanding service sites and/or service hours. Regional offices will utilize the perception of accessibility data to monitor the performance of provider agencies and to plan for service improvement initiatives. CPS staff will work with consumers to identify barriers to accessing services and assist them to seek solutions, working with the provider agencies. It will be necessary to continue these activities throughout the three years of this state plan.
Goal 2:	Georgia will provide community mental health services to more adults with serious mental illness needing publicly funded services.
Indicator 2:	Adults served in the public mental health system
Target 2:	Georgia will increase numbers served by 50 consumers in FY 2006 and FY 2007 over the baseline reported for FY 2005.
Action Plan:	Georgia will continue to provide an array of community services to adults diagnosed with serious mental illness. As funding for adult mental health services is not anticipated to increase during the reporting period, regions will encourage providers to aggressively pursue Medicaid eligibility for individuals who qualify. The state will improve service entry and linkage functions through the implementation of a statewide call center. Georgia expects to implement the statewide call center during FY 2005. The activities stated here will need to continue for FY 2006 and FY 2007.
Goal 3:	Georgia will maintain availability of community services for adults with serious mental illness in need of publicly provided services.
Indicator 3:	Percentage of persons with SMI served in public MHDDAD service system
Target 3:	Percent of treated prevalence will increase by 1% each year for FY 2006 and FY 2007 over the baseline reported in FY 2005.
Action Plan:	With the implementation of the new adult “Core Customer” definition for service eligibility, provider agencies will have a clearer understanding of the population expected to be served. Service providers will be required to distinguish between Brief Intervention and Ongoing Support and Recovery for the consumers that receive services. This change will enable

providers to target services to the population with the more serious mental illnesses and impairments. The Core Customer definition is being implemented in FY 2005. All the actions for this goal will continue for FY 2006 and FY 2007.

CRITERION 4: Targeted Services to Rural and Homeless Populations

Current Activities

The percentage of adults who are homeless and have a serious mental illness in Georgia's rural and urban counties can be determined using published prevalence estimates along with the demographic characteristics from the 2000 US Census Bureau Report. These estimates identify 71,727 adults in Georgia as lacking permanent shelter annually and as having a serious mental illness with 69% living in dense, large metropolitan areas and 31% living in rural areas of the state. While mental health services are available for persons who are homeless, gaining access to those services is a more complex issue. People who are homeless or inadequately housed devote much of their energy to securing housing and other basic needs. This makes it difficult for them to focus on needed mental health treatment services. Equally difficult are the problems providers experience in trying to locate and engage homeless individuals in treatment activities.

Comprehensive mental health services are available in all service areas and may be accessed through a single point of entry for consumers who are also homeless. These homeless individuals with serious mental illness have priority for state services by being among those who are most in need. In FY 2003, of the 24,328 consumers surveyed upon enrollment into the mental health service system, 1,177 consumers reported having experienced homelessness in the past 90 days. Based on this sample, it may be estimated that 5% of those consumers enrolled in community mental health service have recently experienced homelessness. In an effort to replace periodic sampling with a more comprehensive, on-going approach for identifying the housing status on every adult mental health consumers, the statewide MIS system will begin in FY 2005 to identify the housing status for every adult consumer each time that consumer is entered into any mental health service. DHR places a priority on preventing homelessness of individuals who are discharged from state institutions and at risk of homelessness and ensures the statewide availability of dedicated case management, including Assertive community Treatment (ACT), Community support Team (CST), and Community support Individual (CSI). Each of these services includes homelessness as an enrollment eligibility criterion for service. Georgia also supports the provision of specialized homeless services using both state and federal funds.

A statewide strategy to strengthen outreach and engagement activities designed to target the chronically homeless population is supported with Georgia's annual allocation of the Projects to Assist in Transition from Homelessness (PATH) funding. Currently, ten (10) PATH supported services engage, link, and transition the chronic homeless population to mainstream mental health and entitlement resources in the cities of Atlanta, Macon, Savannah and Columbus. The Plan for accomplishing this goal includes improving the ability to identify the hard to reach;

focusing on relationship building approaches; and applying integrated interventions that are sensitive to cultural diversity. Georgia values the team approach to case management and promotes those outreach teams that go into the streets, shelters and familiar homeless gathering locations. A Peer Specialist with homeless experience is an integral member of the team and is used to provide direct service as their unique contribution promotes dignity, respect, acceptance, integration, and choice. The advanced degreed clinician provides clinical expertise and practice while the paraprofessional team member focuses on accessing and coordinating resources. In FY 2003, a total of 1,726 homeless individuals in Georgia received benefit from a PATH funded program, including 830 homeless individuals who were enrolled in ongoing PATH funded service.

The basic resources for supportive housing comes from the partnership between the Department of Human Resources and the Department of Community Affairs (DCA), that state agency which is primarily responsible for housing development. One example of this partnership is the Section 8 Supported Housing Demonstration Project where DCA provide the Section 8 rental subsidies in rural areas of the state and DHR provide the attached support mental health services. A second example of partnership is the collaboration between providers and DCA in the HUD Continuum of Care process. On December 2003, Georgia received \$25 million dollars from HUD for the Continuum of Care Awards Homeless Programs. With DCA as the lead agency, the “balance of state” jurisdiction covering 152 counties was awarded \$7.8 million dollars to fund 23 projects, which included six (6) new shelter plus care programs. These new projects produced 77 units of housing to serve 128 chronically homeless persons with disabilities. In the remaining six (6) jurisdictions, one new shelter plus care program was funded in Cobb County and another was funded in Savannah. In May 2004, DCA sponsored a Supportive Housing Conference **and** property managers came together to build partnerships as a foundation for regional planning and developing more permanent supportive housing facilitated by the Center for Urban Community Services where mental health providers.

Goals, Targets and Action Plans

The goals enumerated for this criterion are long term in nature and will direct the Plan for FY 2005 through FY 2007 unless otherwise stated.

Goal 1:	Improve access to mental health services for consumers who report experiencing homelessness.
Indicator 1:	Mental health consumers enrolled in community services who report experiencing homelessness within the past year.
Target 1:	Percent of those accessing mental health system who report experiencing homelessness will increase by 1% per year for FY 2006 and FY 2007. FY 2005 will represent the baseline for this target.
Action Plan:	MHDDAD state office will support those strategies that strengthen outreach and engagement activities designed to target the chronically homeless and improve the transition of consumers from homeless-specific programs to mainstream service providers. Through multiple funding sources, including mental health block grant, PATH, and state revenues,

supported specialized case management teams go into the streets, shelters, and familiar homeless gather sites to identify and engage those clients who traditionally resist accessing services and link them to mainstream resources while meeting basic needs.

- Goal 2:** Percentage of mental health services delivered outside a clinic setting for consumers living in rural counties will increase. This goal aligns with Recommendation 3.2 in *Achieving the Promise* “improve access to quality care in rural and geographically remote areas.”
- Indicator 2:** Percentage of consumers enrolled in community services in rural areas receiving ACT, CST, or CSI
- Target 2:** Increase by 2% each year for FY 2006 and FY 2007 the number of consumers in rural areas receiving services outside a clinic setting over the baseline reported for FY 2005.
- Action Plan:** MHDDAD state office will provide information to regional office MH/AD Specialist on evidence based practices (EBP) and those community-based services that can be delivered outside the clinic setting under the Rehab. Option to meet the comprehensive mental health needs of those clients living in rural parts of the state. Regions will set expectations of provider agencies for the number of persons to be served using EBP’s. Expanding EBP’s has been a long-term goal of the Georgia system.

CRITERION 5: Management Systems

Current Activities

Georgia’s total budget for adult mental health services is \$243,497,782, of which 64%, or \$156,350,625, is budgeted for community services. Community mental health services for adults are funded through a combination of state, federal and Medicaid resources. All community services are provided through contracts between the MHDDAD regional offices and independent provider entities. Resources are allocated to the seven MHDDAD regional offices based on historical distribution and funding formulas that include factors for poverty and population.

The Georgia General Assembly appropriates funding for services during its annual session when it passes the state budget. The budget for the DMHDDAD is included as part of the overall budget for the Department of Human Resources. The board of DHR must first accept requests for new appropriations for inclusion in the DHR budget, which is then sent to the governor for consideration for inclusion in his budget proposal. The two bodies of the General Assembly pass budgets that are then brought to a conference committee to finalize the budget for the coming state fiscal year. For the past three years, the state has experienced declining revenues and the governor has requested all state agencies to submit budget requests reflecting a mandated percentage reduction. Most of the reductions taken by MHDDAD have been in administration or in hospital services, maintaining the focus on community-based services. Because of these budget restraints however, there have not been increased appropriations for services even though

numbers needing services have increased. This has forced providers to concentrate service resources in more cost effective services, and limit utilization of services such as individual therapy, which are less cost effective.

Staffing requirements are established in the service standards for each category of service, and are specified in the Provider Manual that is included as an attachment to each provider contract. Staffing requirements are the same for Medicaid funded and state grant-in-aid funded services. The ERO service utilization monitoring includes review of staffing to assure that both numbers of staff and credentials meet the guidelines.

As discussed in Section II of this document, standards require agencies to plan for staff competency development and training. Some training for provider staff is offered by DMHDDAD through a variety of conferences and training events. State and regional staff with subject matter expertise also provide technical assistance. Training of emergency personnel is also described in Section II.

The following tables indicate how the state spent MHBG funds for state FY 2004 and the plans for expenditures for FY 2005. Because Georgia's service contracting is done annually, it is not possible to forecast the expenditures beyond the current fiscal year. New Planned Expenditures tables will be provided with the annual application for FY 2006 and FY 2007.

**FY 2004 FEDERAL MENTAL HEALTH BLOCK GRANT FUNDS
(ADULT MENTAL HEALTH SERVICES, CONTRACTED)**

REGION	PROVIDER	PLANNED AMOUNT	SERVICES
NORTH	Cobb County CSB	\$ 167,332	1,2,3,4,5,7
	Douglas County CSB	\$ 29,529	1,2,3,4,5,7
	Georgia Mountains CSB	\$ 289,368	1,2,3,4,5,7
	Haralson County Board of Health	\$ 17,712	1,3,4,5,7
	Highland Rivers CSB	\$ 211,545	1,2,3,4,5,7
	Lookout Mountain CSB	\$ 78,829	1,2,3,4,5,6,7
METRO	Behavioral Health Link	\$ 107,073	2
	Clayton County CSB	\$ 285,538	1,3,4,5,6,7
	Community Friendship, Inc.	\$ 91,861	7
	Compeer Atlanta	\$ 3,000	4
	DeKalb Community Service Board	\$ 188,294	1,2,3,4,5,6,7

REGION	PROVIDER	PLANNED AMOUNT	SERVICES
	Fulton-DeKalb Hospital Authority	\$ 382,962	1,3
	Fulton County CSB	\$ 18,927	1,2,3,4,5
	GA Parent Support Network	\$ 125,000	4
	GA Resources Education and Advocacy for Treatment for Deaf Adults	\$ 50,000	1
	Gwinnett/ Rockdale/ Newton CSB	\$ 187,361	1,2,3,5,7
	Northside Hospital	\$ 24,000	1,3,4,5
WEST CENTRAL	McIntosh Trail CSB	\$ 72,600	1,2,3,4,5,7
	Middle Flint CSB	\$ 43,500	1,2,3,4,5,7
	New Horizons CSB	\$ 614,018	1,2,3,4,5,7
	Pathways CSB	\$ 90,600	1,2,3,4,5,7
	Worktec	\$ 48,661	7
CENTRAL	CSB of Middle Georgia	\$ 89,184	1,2,3,5,6,7
	Oconee CSB	\$ 59,039	1,2,3,5,6,7
	Phoenix Center CSB	\$ 60,796	1,2,3,5,6,7
	River Edge CSB	\$ 387,985	1,2,3,5,6,7
EAST CENTRAL	Advantage Behavioral Health	\$ 144,946	1,3,4,5,6,7
	CSB of East Central Georgia	\$ 119,376	1,3,4,5,6,7
	Ogeechee CSB	\$ 116,485	1,3,4,5,6,7
SOUTH EAST	Albany Area Community Service Board	\$ 136,481	1,3,7
	American Work	\$ 43,750	4,7
	Georgia Pines CSB	\$ 45,930	7

REGION	PROVIDER	PLANNED AMOUNT	SERVICES
	South Georgia CSB	\$ 101,964	1,2,3,4,5,6,7
SOUTH WEST	American Work	\$ 43,750	4
	Gateway Center for Human Development	\$ 182,981	1,2,3,5,6,7
	Pineland Community Service Board	\$ 85,969	1,2,3,4,5,6,7
	Satilla CSB	\$ 81,597	1,2,3,5,6,7
	<u>TOTAL</u>	\$4,827,943	

SERVICES:

1. Outpatient services
2. 24-hour-a-day emergency care services
3. Partial hospitalization services, or psycho-social rehabilitation services
4. Consumer directed programs
5. Residential services
6. Respite services
7. Supported employment services

**FY 2005 FEDERAL MENTAL HEALTH BLOCK GRANT FUNDS
(ADULT MENTAL HEALTH SERVICES, PLANNED)**

REGION	PROVIDER	PLANNED AMOUNT	SERVICES
NORTH	America Works, Inc.	\$ 87,500	4
	Cobb County CSB	\$ 167,332	1,2,3,4,5,6,7
	Douglas County CSB	\$ 29,529	1,2,3,4,5,6,7
	Georgia Mountains CSB	\$ 289,368	1,2,3,4,5,6,7
	Haralson County Board of Health	\$ 17,712	1,2,3,4,5,7
	Highland Rivers CSB	\$ 211,545	1,2,3,4,5,7
	Lookout Mountain CSB	\$ 78,829	1,2,3,4,5,6,7
METRO	Clayton County CSB	\$ 285,538	1,2,3,4,5,6,7
	Community Friendship, Inc.	\$ 91,861	7

	DeKalb CSB	\$ 188,294	1,2,3,4,5,6,7
	Fulton County	\$ 18,927	1,3,6,7
	Fulton-DeKalb Hospital Authority	\$ 382,962	1,2
	GA West Mental Health Foundation	\$ 3,000	1,5
	GA Parent Support Network	\$ 125,000	4
	GA Resources Education Advocacy for Treatment for Deaf Adults	\$ 50,000	1
	Gwinnett/Rockdale/Newton CSB	\$ 187,361	1,2,3,4,5,6,7
	Integrated Health Resources, LLC	\$ 107,073	2
	Northside Hospital	\$ 24,000	1,2
	Regional Reserves	\$ 219,000	
WEST CENTRAL	Clayton County BOE	\$ 48,661	7
	McIntosh Trail CSB	\$ 72,600	1,2,3,4,5,6,7
	Middle Flint CSB	\$ 43,500	1,2,3,4,5,6,7
	New Horizons CSB	\$ 614,018	1,2,3,4,5,6,7
	Pathways CSB	\$ 90,600	1,2,3,4,5,6,7
CENTRAL	CSB of Middle Georgia	\$ 89,184	1,2,3,5,6,7
	Oconee CSB	\$ 59,039	1,2,3,4,5,6,7
	Phoenix Center CSB	\$ 132,409	1,2,3,4,5,6,7
	River Edge CSB	\$ 387,985	1,2,3,4,5,6,7
EAST CENTRAL	Advantage Behavioral Health	\$ 144,946	1,3,4,5,6,7
	CSB of East Central Georgia	\$ 119,376	1,3,4,5,6,7
	Ogeechee CSB	\$ 116,485	1,3,4,5,6,7

SOUTH WEST	Albany Area CSB	\$ 136,481	1,2,3,4,5,7
	American Works, Inc.	\$ 43,750	4
	Georgia Pines CSB	\$ 45,930	7
	South Georgia CSB	\$ 101,964	1,2,3,4,5,7
SOUTH EAST	American Works, Inc.	\$ 43,750	4
	Gateway CSB	\$ 182,981	1,2,3,4,5,6,7
	Pineland CSB	\$ 85,969	1,2,3,4,5,6,7
	Satilla CSB	\$ 81,597	1,2,3,5,6,7
TOTAL		\$5,206,056	

SERVICES:

1. Outpatient services
2. 24-hour-a-day emergency care services
3. Partial hospitalization, or psycho-social rehabilitation services
4. Consumer directed programs
5. Residential services
6. Respite services
7. Supported employment services

Goals, Targets and Action Plans

The goals enumerated for this criterion are long term in nature and will direct the Plan for FY 2005 through FY 2007 unless otherwise stated.

Goal 1: A majority of mental health services for adult consumers will be delivered in community settings rather than in psychiatric hospitals

Indicator 1: Total budgeted funds for adult mental health community services as a percentage of total adult mental health budget

Target 1: Percentage of funding for community services will continue to be the majority of the adult mental health services budget

Action Plan: DMHDDAD will continue to focus on community services for adults with mental illness. Inpatient treatment will be utilized as a “treatment of last resort” for individuals whose needs cannot be met in community settings. State and regional office staff will provide technical assistance to community service providers and to hospital staff regarding continuity of care and appropriate service planning to encourage retention in community services and to facilitate the earliest possible return to community services following any necessary hospitalizations. These actions will be required throughout all years of the plan period.

Goal 2:	A consistently trained and competent consumer work force will be available to be employed as Peer Specialists in Peer Supports, ACT, CST, and Psycho-Social Rehabilitation. This goal relates to Recommendation 5.3 in the New Freedom Commission report “improve and expand the workforce providing evidence-based mental health services and supports.”
Indicator 2:	Number of Peer Specialists who complete training and become certified each year
Target 2:	Train and certify at least an additional 50 CPS each year for FY 2005, FY 2006 and FY 2007.
Action Plan:	The DMHDDAD will contract with the Georgia Mental Health Consumer Network to conduct at least two training and certification series annually for FY 2005, FY 2006 and FY2007. MHBG resources will be utilized to fund a position in the DMHDDAD Office of Consumer Relations to monitor the training, certify the test results, award certificate and coordinate quarterly continuing education for CPS staff.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 1**

State Specific Performance Indicator

Goal 1:	Consumers will obtain and maintain meaningful employment in integrated [community] settings. This goal relates to Recommendation 5.2 of <i>Achieving the Promise</i> , to “advance evidence based practices.”
Target:	20% of adult mental health consumers enrolled in services for at least three months will be competitively employed in FY2005 with a 1% increase each year for FY2006 and FY2007
Population:	Adults diagnosed with a serious mental illness
Criterion:	Comprehensive, community based mental health system
Brief Name:	Competitive Employment
Indicator 1:	Mental health consumers enrolled in services for at least three months engaged in competitive employment
Measure:	Percentage of consumers enrolled in community services for at least three months who are engaged in competitive employment <u>Numerator:</u> Number of consumers enrolled in community services at least three months who have added or released services during the reporting period and who are employed full or part-time in integrated settings <u>Denominator:</u> Consumers enrolled in community services at least three months who have added or released services during the reporting period
Source(s) of Information:	State wide information system
Significance:	Consumer employment is the top priority for the Georgia Mental Health Consumer Network, and all of Georgia’s MHDDAD Regions are in support of consumer initiatives regarding employment. It is competitive employment that fosters consumer independence and is a key factor in the recovery process. This measure includes full time, part time and supported employment. Those individuals identified as “not in the labor force” are excluded from this measure.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 1
Core Performance Indicator

Goal 2:	Evidence-Based practice services will be available to consumers. This goal also relates to “advancing evidence based practices” called for in Recommendation 5.2 in <i>Achieving the Promise</i> .
Target:	To increase the number of adults with SMI receiving EBP services by 50 each year for FY 2006 and FY 2007 over the baseline data reported for FY 2005
Population:	Adults diagnosed with a serious mental illness
Criterion:	Comprehensive, community based mental health system
Brief Name:	Evidence-Based Practice Services
Indicator 2.1:	Adults with SMI receiving Evidence-Based Practice services
Measure:	Number of SMI adults aged 18+ receiving any of the seven adult evidence based practices
Source(s) of Information:	Statewide Information System
Significance:	Though not all persons with serious mental illness need all the services identified as Evidence-Based Practices (EBP), research has demonstrated the effectiveness of these services for many consumers. For this indicator, the percentage of adult mental health consumers enrolled in at least one EBP will be reported. The EBPs that are included in this reporting are ACT, Illness Self Management (Peer Support), Supported Employment, Supported Housing, and New Generation Antipsychotic Medications. While Georgia is beginning to offer some integrated services for persons with co-occurring mental illness and addictive disorders, our data system is not yet able to gather data on numbers enrolled in these services. At this time Georgia contracts with NAMI GA to provide Family-to Family education. Those families are not included in Georgia’s information system. Data reported for FY 2005 will be baseline for this indicator.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 1**

Core Performance Indicator

Goal 2:	Evidence-Based practice services will be available statewide to consumers
Target:	At least five Evidence-Based Practice Services will be available to adults with SMI in Georgia
Population:	Adults diagnosed with a serious mental illness
Criterion:	Comprehensive, community based mental health system
Brief Name:	Evidence-Based Practice Services
Indicator 2.2:	Actual Evidence-Based Practices provided in Georgia
Measure:	Provision (Yes/No) of each of seven adult EBPs
Source(s) of Information:	State wide information system
Significance:	Georgia currently offers ACT, Illness Self Management (Peer Support), Supported Employment, Supported Housing and New Generation Antipsychotic Medications. In addition, Georgia is beginning to offer integrated treatment services for individuals with co-occurring mental illness and addictive disorders. The present information system is not yet able to identify numbers of consumers enrolled in those services, however, so Integrated Treatment for Co-Occurring Disorders will not be included in the reporting for this indicator. Georgia contracts with NAMI GA to provide Family-to-Family education services in the state. Those families are not included in the state information system and will not be included in this reporting.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 1**

State Specific Performance Indicator

Goal 3:	Access to services for adults with serious mental illness who are in local jails or released on probation or parole will be improved
Target:	Increase the number of individuals receiving TAPP services by 10 per year for FY 2005, FY 2006, and FY 2007
Population:	Adults diagnosed with a serious mental illness
Criterion:	Comprehensive, community based mental health system
Brief Name:	Criminal Justice
Indicator 3:	Number of enrolled consumers who receive Transition and Aftercare for Probationers and Paroles (TAPP) services
Measure:	Total # of consumers enrolled in TAPP services during the fiscal year
Source(s) of Information:	Statewide Information System
Significance:	There is mounting concern statewide and nationally about mental health service provision to persons in state and local custody, as well as numerous related issues. All regions are involved in service provision to persons involved with the criminal justice system. The TAPP services program is a collaborative effort between MHDDAD and the Georgia Department of Corrections, to provide linkage to community mental health services for individuals exiting prison on probation or parole. This indicator has been reported for the past three years and targets will be based on previous data.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 1
Core Performance Indicator

Goal 4:	Decrease the number of consumers being readmitted to state hospitals within 30 and 180 days of being discharged
Target:	Reduce 30-day readmission rates by 0.5% each year for FY 2005, FY 2006, and FY 2007 Reduce 180-day readmission rates by 0.5% each year for FY 2006 and FY 2007 over the baseline established for FY 2005
Population:	Adults diagnosed with a serious mental illness
Criterion:	Comprehensive, community based mental health system
Brief Name:	Re-admissions
Indicator 4.1:	Percentage of persons readmitted to adult mental health unit (non-forensic) state hospital inpatient care within 30 days of discharge
Indicator 4.2:	Percentage of persons readmitted to adult mental health unit (non-forensic) state hospital inpatient care within 180 days of discharge
Measure:	<u>Numerator:</u> Total number of adult mental health non-forensic admission episodes during the reporting period in which the client had been discharged from any state operated adult mental health, non-forensic unit within the 30/180 days preceding the admission <u>Denominator:</u> Total number of adult mental health non-forensic admissions to state operated adult mental health, non-forensic units that occurred during the reporting period
Source(s) of Information:	Hospital information (BHIS)
Significance:	High numbers of consumers readmitted to state psychiatric inpatient care within 30/180 days of being discharged may reflect treatment failure, premature discharges or lack of community follow-up, which are inverse aspects of good outcomes and high quality/appropriate care. This indicator has been reported for several years for 30-day readmission, but the data for 180-day readmission reported for FY 2005 will be baseline for that indicator.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 1
Core Performance Indicator**

Goal 5:	Consumers will perceive positive change as a result of services received
Target:	Positive response about outcomes of services will increase by 1% each year for FY 2006 and FY 2007 over the baseline report for FY 2005
Population:	Adults with a serious mental illness
Criterion:	Comprehensive, community-based system
Brief Name:	Consumer Perception of Care
Indicator 5:	Consumers reporting positively about outcomes
Measure:	<u>Numerator:</u> Number of positive responses reported in the outcome domain on the adult consumer survey <u>Denominator:</u> Total number of responses reported in the outcome domain on the adult consumer survey
Source(s) of Information:	PERMES Consumer Survey (MHSIP Adult Survey)
Significance:	This indicator captures the consumer's perception of the effectiveness of services and the positive outcomes that resulted from treatment and support received. Positive response for this measure is based on the responses to several survey questions related to service effectiveness. Data for FY 2005 will be the baseline for this indicator.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 2
State Specific Performance Indicator**

Goal 1:	Increase accessibility of public mental health services
Target:	Positive rating of access to services will increase by 1% per year for FY 2005, FY 2006 and FY 2007.
Population:	Adults diagnosed with a serious mental illness
Criterion:	Mental Health System Data Epidemiology
Brief Name:	Service Access
Indicator 1:	Percentage of enrolled consumers who rate access to and availability of mental health services positively
Measure:	<p><u>Numerator:</u> # of adult mental health consumers participating in PERMES survey who rate access to mental health services positively</p> <p><u>Denominator:</u> Total # of adult mental health consumers participating in PERMES survey</p>
Source(s) of Information:	PERMES Consumer Survey (MHSIP Adult Survey)
Significance:	Timely and convenient access to services is a major value of the public behavioral health system and a major factor in ensuring that persons receive needed services. The consumers' perception of access is a measure of ease in obtaining some level of service and barriers encountered, from the perspective of those who utilize services. This measure does not address persons who were unable to access the service delivery system. This indicator was previously reported and actual data from state FY 2004 will be utilized as the baseline for this indicator.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 2**

Core Performance Indicator

Goal 2:	Georgia will provide community mental health services for adults with serious mental illness needing publicly funded services
Target:	Georgia will increase numbers served by 50 consumers in FY 2006 and FY 2007 over the baseline reported for FY 2005
Population:	Adults diagnosed with a serious mental illness
Criterion:	Mental Health System Data Epidemiology
Brief Name:	Increased access to services
Indicator 2:	Adults served in the public mental health system
Measure:	Number of adults age 18 + served
Source(s) of Information:	State wide information system
Significance:	The number served by the public MHDDAD system reflects only those enrolled in services, and does not include individuals who receive services from other agencies or those wanting or needing services but not enrolled in services. It is not anticipated that new resources will be available to the system in the coming three years, so the targets for increasing numbers to be served are set very low in recognition of static funding.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 2
State Specific Performance Indicator**

Goal 3:	Georgia will maintain availability of community services for adults with serious mental illness in need of publicly provided services
Target:	Percent of treated prevalence will increase by 1% each year for FY 2006 and FY 2007 over the baseline reported in FY 2005
Population:	Adults diagnosed with a serious mental illness
Criterion:	Mental Health System Data Epidemiology
Brief Name:	Treated Prevalence
Indicator 3:	Percent of persons with SMI served in public MHDDAD service system
Measure:	Percent of estimated prevalence served in the public MHDDAD system <u>Numerator:</u> Number of adults with mental health diagnoses enrolled in services <u>Denominator:</u> Number of persons in Georgia age 18 + with SMI, as provided by CMHS
Source(s) of Information:	Statewide Information system
Significance:	The estimate of prevalence of SMI among the state population age 18 and older does not factor in poverty or other issues that relate to needing services from a public mental health system. The number served by the public MHDDAD system reflects only those enrolled in services, and does not include individuals who receive services from other agencies or those wanting or needing services but not enrolled in services. Data reported for FY 2005 will be used as baseline for this indicator. As funding for services is not expected to be increased in the coming three years, targets for this indicator are minimal.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 4**

State Specific Performance Indicator

Goal 1:	The percentage of mental health services delivered outside a clinic setting for consumers who report being homeless upon entry into a service will increase.
Target:	A 1% increase over the baseline reported in FY 2005 each year for FY 2006 and FY 2007 the number of consumers receiving services outside a clinic setting who report being homeless upon entry into any service.
Population:	Adults diagnosed with a serious mental illness.
Criterion:	Targeted Services to Homeless Populations/Targeted Services to Rural Populations
Brief Name:	Homeless Access to Services
Indicator 1:	Percentage of consumers who report being homeless upon entry into service receiving community services including Assertive community Treatment (ACT), Community Support Team (CST), or Community Support Individual (CSI) services
Measure:	<p>The percentage of mental health consumers who report being homeless who are enrolled in ACT, CST, or CSI.</p> <p><u>Numerator:</u> Unduplicated count of adult mental health consumers who report being homeless upon entry into any service who are enrolled into ACT, CST, or CSI.</p> <p><u>Denominator:</u> Unduplicated count of adult mental health consumers who report being homeless upon entry into any mental health service.</p>
Source(s) of Information:	Statewide information system
Significance:	While mental health services are available to persons who are homeless, access to those services is a more complex issue and has been selected as an indicator for this criterion. Having appropriate housing options combined with case management and other community resources is key to preventing relapse and homelessness throughout the recovery process. Intensive case management provides the necessary link to supportive services in the community and helps people move toward independent living.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 4
State Specific Performance Indicator**

Goal 2:	Percentage of mental health services delivered outside a clinic setting for consumers living in rural counties will increase. This goal aligns with Recommendation 3.2 in <i>Achieving the Promise</i> “improve access to quality care in rural and geographically remote areas.”
Target:	Increase by 2% each year for FY 2006 and FY 2007 the number of consumers in rural areas receiving services outside a clinic setting over the baseline reported for FY 2005
Population:	Adults diagnosed with a serious mental illness
Criterion:	Targeted Services to Homeless Populations/Targeted Services to Rural Populations
Brief Name:	Rural Mental Health Services
Indicator 2:	Percentage of consumers enrolled in community services in rural areas receiving Assertive Community Treatment (ACT), Community Support Team (CST) or Community Support Individual (CSI) services
Measure:	<u>Numerator:</u> Number of rural area adult mental health consumers enrolled in ACT, CST and/or CSI <u>Denominator:</u> Total number of enrolled adult mental health consumers in rural areas
Source(s) of Information:	Statewide Information System
Significance:	Individuals residing in rural areas have difficulties accessing services because of distance to service locations and lack of transportation. With the movement to “out-of-clinic” services available under the Medicaid Rehab Option, services can be taken to consumers in their homes and in locations other than mental health clinic sites. Rural designation relates to counties that lie completely outside a Metropolitan Statistical Area (MSA). Georgia has 159 counties, with 23% being included in MSAs and 77% designated as rural. Data reported for FY 2005 will provide a baseline for this indicator.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 5**

State Specific performance Indicator

Goal 1:	A majority of mental health services for adult consumers will be delivered in community settings rather than in psychiatric hospitals		
Target:	Percentage of funding for community services will continue to be the majority of the adult mental health services budget		
Population:	Adults diagnosed with a serious mental illness		
Criterion:	Management Systems		
Brief Name:	Community service funding		
Indicator 1:	Total budgeted funds for adult mental health community services as a percentage of total adult mental health budget		
Measure:	<u>Numerator:</u>	Total adult mental health community budget.	
	<u>Denominator:</u>	Total adult mental health budget	
Source(s) of Information:	State budget reports		
Significance:	Georgia is continuing to expand community based public mental health services and reduce reliance on inpatient psychiatric hospital services. Georgia has reduced inpatient bed capacity for the past several years, but it does not seem likely that further reductions will be proposed in the near term. As total funding for services is not expected to increase during the coming three-year period, maintaining community predominance is the target for this indicator.		

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
CRITERION 5
State Specific Administrative Indicator**

Goal 2:	A consistently trained and competent consumer work force will be available to be employed as Peer Specialists in Peer Supports, Assertive Community Treatment (ACT), Community Support Teams (CST), and Psycho-social Rehabilitation. This goal relates to Recommendation 5.3 in the New Freedom Commission report “improve and expand the workforce providing evidence-based mental health services and supports.”
Target:	Train and certify at least an additional 50 CPS each year for FY 2005, FY 2006 and FY 2007
Population:	Adults diagnosed with a serious mental illness.
Criterion:	Management Systems
Brief Name:	Trained Peer Specialists
Indicator 2:	Number of Peer Specialists who complete training and become certified each year
Measure:	Total number of consumers who complete the Peer Specialist training program by meeting all curriculum, supervisory, and credentialing requirements
Source(s) of Information:	The DMHDDAD Office of Consumer Relations will submit a listing of those consumers who complete the Peer Specialist training and certification.
Significance:	The Certified Peer Specialist job qualifications are defined in the Medicaid Program manual. This cohort of staff is vital to transformation of the system to a more recovery-focused approach. This indicator has been reported for the past three years and targets will be based on FY 2004 data.

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Competitive Employment

Population: Adults diagnosed with a serious mental illness

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY2006 Target	FY2007 Target
Indicator: Mental health consumers enrolled in services for at least three months engaged in competitive employment	NA	NA	Baseline	+1%	+1%
Numerator: Number of consumers enrolled in community services at least three months who have added or released services during the reporting period and who are employed full or part-time in integrated settings.	NA	NA			
Denominator: Consumers enrolled in community services at least three months who have added or released services during the reporting period.	NA	NA			

Name of Performance Indicator: Evidenced-Based Practice Services

Population: Adults diagnosed with a serious mental illness

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY2006 Target	FY2007 Target
Indicator: Adults with SMI receiving Evidence-Based Practice services.	Number served	Number served	Number served	Number served	Number served
Measure: Number of SMI adults aged 18+ receiving any of the seven adult evidence based practices.	N/A	N/A	Baseline		

Name of Performance Indicator: Evidence-Best Practice Services

Population: Adults diagnosed with a serious mental illness

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY2003 Actual		FY2004 Projected		FY2005 Target		FY2006 Target		FY2007 Target	
Indicator: Actual Evidence-Based Practices provided in Georgia	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
Assertive Community Treatment (ACT)		X		X		X		X		X
Illness Self Management (Peer Support)		X		X		X		X		X
Supported Employment		X		X		X		X		X
Supported Housing		X		X		X		X		X
New Generation Medications		X		X		X		X		X
Integrated Treatment for Co-Occurring		X		X		X		X		X
Family Education		X		X		X		X		X

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Criminal Justice

Population: Adults diagnosed with a serious mental illness

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Number of enrolled consumers who receive Transition and Aftercare for Probationers and Paroles (TAPP) services.	Number served	Number served	Number served	Number served	Number served
Measure: Number of consumers enrolled in TAPP services during the fiscal year.	1,105	1584	+10	+10	+10

Name of Performance Indicator: Re-Admissions

Population: Adults diagnosed with a serious mental illness

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of persons readmitted to adult mental health unit (non-forensic) state hospital inpatient care within 30 days of discharge.	13.2%	13.2%	- 0. 5%	- 0. 5%	- 0. 5%
Numerator: Number of adult mental health (non-forensic) admission episodes during the reporting period in which the client is discharged from a state operated inpatient hospital unit within the 30 days preceding the admission	2,302				
Denominator: Number of adult mental health (non-forensic) admissions to state hospital inpatient units during the reporting period	17,380				

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of persons readmitted to adult mental health unit (non-forensic) state hospital inpatient care within 180 days of discharge	N/A	N/A	Baseline	- 0. 5%	- 0. 5%
Numerator: Number of adult mental health (non-forensic) admission episodes during the reporting period in which the client is discharged from a state operated inpatient hospital unit within the 180 days preceding the admission	N/A	N/A	Baseline		
Denominator: Number of adult mental health (non-forensic) admissions to state hospital inpatient units during the reporting period	N/A	N/A	Baseline		

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Consumer Perception of Care

Population: Adults diagnosed with a serious mental illness

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Consumer reporting positively about outcomes	N/A	N/A	Baseline	+1%	+1%
Numerator: Number of positive responses reported in the outcome domain on the adult consumer survey	N/A	N/A	Baseline		
Denominator: Number of responses reported in the outcome domain on the PERMES adult Consumer Survey	N/A	N/A	Baseline		

Name of Performance Indicator: Service Access

Population: Adults diagnosed with a serious mental illness

Criterion: Mental Health System Data Epidemiology

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of enrolled consumers who rate access to and availability of mental health services positively	87.8%	81.2%	+1%	+1%	+1%
Numerator: Number of positive responses reported in the access to mental health services domain on the adult consumer survey	4,901				
Denominator: Number of responses reported in the access to mental health services domain on the PERMES adult Consumer Survey	5,579				

Name of Performance Indicator: Increased Access to Services

Population: Adults diagnosed with a serious mental illness

Criterion: Mental Health System Data Epidemiology

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Adults served in the public mental health system	Number served	Number served	Number served	Number served	Number served
Measure: Number of adults aged 18+ served	N/A	100,822	Baseline	+50	+50

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Treated Prevalence

Population: Adults diagnosed with a serious mental illness

Criterion: Mental Health System Data Epidemiology

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of persons with SMI served in public MHDDAD service system	N/A	N/A	Baseline	+1%	+1%
Numerator: Number of adults with mental health diagnoses enrolled in services	N/A	N/A	Baseline		
Denominator: Number of persons in Georgia age 18+ with SMI, as provided by CMHS	N/A	N/A	Baseline		

Name of Performance Indicator: Homeless Access to Services

Population: Adults diagnosed with a serious mental illness

Criterion: Targeted Services to Homeless Populations/Targeted Services to Rural Populations

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Mental health consumers enrolled in community services who report experiencing homelessness within the past year	N/A	N/A	Baseline	+1%	+1%
Numerator: Unduplicated count of adults receiving the DLA functional assessment who report an episode of homelessness within the past year upon enrollment in mental health services	N/A	N/A	Baseline		
Denominator: Unduplicated count of adults receiving the PERMES DLA functional assessment upon enrollment in mental health services	N/A	N/A	Baseline		

Name of Performance Indicator: Rural Mental Health Services

Population: Adults diagnosed with a serious mental illness

Criterion: Targeted Services to Homeless Populations/Targeted Services to Rural Populations

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of consumers enrolled in community services in rural areas receiving ACT, CST, or CSI services	N/A	N/A	Baseline	+2%	+2%
Numerator: Number of rural area adult mental health consumers enrolled in ACT, CST, or CSI	N/A	N/A	Baseline		
Denominator: Number of enrolled adult mental health consumers in rural areas	N/A	N/A	Baseline		

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Community Service Funding

Population: Adults diagnosed with a serious mental illness

Criterion: Management Systems

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Total budgeted funds for adult mental health community services as a percentage of total adult mental health budget	N/A	N/A	Baseline	Maintain	Maintain
Numerator: Total adult mental health community budget	N/A	N/A	Baseline		
Denominator: Total adult mental health budget	N/A	N/A	Baseline		

Name of Performance Indicator: Trained Peer Specialists

Population: Adults diagnosed with a serious mental illness

Criterion: Management Systems

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Number of Peer Specialists who complete training and become certified each year	Number trained	Number trained	Number trained	Number trained	Number trained
Measure: Number of consumers who complete the Peer Specialist Certification training program by meeting all curriculum, supervisory, and credentialing requirements	57	50	50	50	50

CHILD AND ADOLESCENT PLAN

CRITERION 1: Comprehensive Community-Based Mental Health Service System

Current Activities

Georgia provides a comprehensive community based system of mental health care for youth with serious emotional disturbance (SED) and their families who need public services. As reflected in Section II of this document, a full array of community based mental health services is provided in each service area of the state, including evidence based practice services identified as most effective for youth with SED. While not all services are available in every one of Georgia's 159 counties, each county is included in one of the state's 25 service areas. The full array of services is provided in the lead counties of the services areas, at a minimum, with some services available in satellite offices or through mobile service delivery. The following services for youth with SED and their families are provided across the state through a combination of state, federal and Medicaid funding:

- **Screening, Crisis and Outreach Services**
 - Outreach
 - Diagnostic/Functional Assessment
 - Crisis Intervention
 - Community Based Inpatient Services
 - Pharmacy Services
 - Consumer and Family Education
 - Family Support
 - Respite
- **Outpatient Services**
 - Physician Assessment and Care
 - Nursing Assessment and Health Services
 - Medication Administration
 - Intensive Family Intervention
 - Individual Counseling
 - Group Training/Counseling
 - Family Training/Counseling
 - Community Support Individual
 - Community Support Team
- **Day and Employment Services**
 - Child and Adolescent Day Treatment
 - Child and Adolescent Day Supports
 - Activity Therapy
- **Personal Living and Residential Services**

Therapeutic Group Home
Therapeutic Foster Care
Outdoor Therapeutic Programs

- **Service Entry and Linkage** – Single point of entry to the system

There are limited evidence based practice services for youth with SED across the nation, due to the dearth of research available on EBP. The DMHDDAD recognizes therapeutic foster care as one of the EBP's that is available, but service expansion is needed to help divert youth from more intensive out of home residential placements and/or state hospital admissions. Intensive Family Intervention, Community Support services, Family Support Services and Respite Care are best practice services for youth with SED and their families that the DMHDDAD has funded and wants to expand. Because many of the service areas in Georgia cover multiple counties, many of which are very rural and remote, service providers are reluctant to employ the IFI teams and do not consider it cost effective because of the great distances that teams would be required to travel to provide services. Additionally, in the more rural areas of the state, the shortage of licensed and credentialed mental health professionals make it difficult to secure the level of clinical expertise required to comply with the model. More work is needed to increase the number of IFI providers in the system.

Medicaid is the fund source for about half of the individuals receiving services in the Georgia system. With the move to Rehab Option services in 2001, more services are available in settings other than mental health clinics. Many of the provider agencies have faced challenges in learning the new service structure and in transitioning mental health staff from office settings to more mobile service delivery. The Medicaid External Review Organization (ERO), that manages the Medicaid funding for Rehab Option services, has provided technical assistance and training for provider agencies to help with this transition and to increase understanding of and compliance with the Medicaid service standards.

The state utilizes contracting requirements and performance expectations to foster implementation of the desired array of services in the system. Combined with training and technical assistance, these factors have enabled Georgia to expand the available service capacity within the state. A full discussion of the comprehensive nature of services provided in the system, as required by the statutory requirements that establish the block grant, is included in Section II of this document.

As mentioned in Section II, the DHR Level of Care Program (formerly known as MATCH) administered by DFCS purchases out of home placements, including intensive and intermediate residential treatment, therapeutic foster care, basic group home care and basic foster care services provided by private agencies. This is a priority population for all of our child-serving systems for diversion and return from out-of-home placements, and will require focused state level planning for strategies to develop step down alternatives and increased community based capacity to decrease the number of youth referred to the LOC System.

The DMHDDAD has also provided statewide training opportunities for the regions and their providers during the past two state fiscal years. As mentioned in Section II, training and technical assistance were provided that focused on crisis intervention skill development and development of crisis stabilization and intervention services and on developing and sustaining systems of care for youth with SED and their families with input from a large variety of stakeholders.

Goals, Targets and Action Plans

The goals enumerated for this criterion are long term in nature and will direct the Plan for FY 2005 through FY 2007 unless otherwise stated.

- Goal 1:** Evidenced-Based Practice services will be available to all youth with SED. This goal relates to Recommendation 5.2 of *Achieving the Promise*, to “advance evidence based practices.”
- Indicator 1.1:** Youth with SED receiving Therapeutic Foster Care services
- Target 1:** Increase number of youth with SED receiving EBP services by 10 in FY 2006 and FY 2007 over the baseline data reported for FY2005.
- Action Plan:** With the new LOC system, the Community Services Boards (public mental health providers) can now enroll and become LOC providers of therapeutic foster care with a much higher reimbursement rate for serving youth in DFCS custody or youth with DJJ commitment status. The DMHDDAD will provide technical assistance to regions and providers to foster enrollment in the new LOC and expansions of TFC services under this new rate for CSB providers. The activities cited here will be employed for all three years in this state plan.
- Indicator 1.2:** Percentage of DMHDDAD regions that have Therapeutic Foster Care Services available to youth with SED and their families
- Target 1.2:** Evidenced-based practice services will be available in all seven DMHDDAD regions in Georgia.
- Action Plan:** MHDDAD state office staff will provide information on TFC services to regional office MH/AD Specialists to assist them in providing technical assistance to service provider agencies regarding expansion of TFC programs and enrollment into the new LOC system. Regions will set expectations of provider agencies for the number of persons to be served in TFC programs. The activities cited here will be employed for all three years in this state plan.
- Goal 2:** Best Practice/Promising Practice services will be available to all youth with SED
- Indicator 2.1:** Percentage of youth receiving best practice/promising practices services
- Target 2.1:** Increase percentage of youth with SED receiving best practice/promising practice services by 1% in FY 2006 and FY 2007 over the baseline data reported for FY 2005

Action Plan:	MHDDAD state office staff will provide information on Intensive Family Intervention, community support services, family support and respite care to regional office MH/AD Specialists to assist them in providing technical assistance to service provider agencies regarding expansion of these programs. Additionally, DMHDDAD will work with Regional Offices and their contracted providers on strategies to improve outreach such as out-stationing staff to child welfare offices, schools and juvenile courts. The activities cited here will be employed for all three years in this state plan.
Goal 3:	Decrease the number of consumers being readmitted to state hospitals within 30 and 180 days of being discharged
Indicator 3.1:	Percentage of youth readmitted to state hospital inpatient care within 30 days of discharge
Target 3.1:	Reduce 30-day readmission rates by 0 .5% each year for FY2005, 2006 and 2007
Indicator 3.2:	Percentage of youth readmitted to state hospital inpatient care within 180 days of discharge
Target 3.2:	Reduce 180-day readmission rates by 0.5% each year for FY2006 and 2007 over the baseline established for FY2005
Action Plan:	State office staff will provide technical assistance to regions as requested to improve continuity of care efforts. Regional offices will enhance continuity of care efforts between hospital and community services. Greater attention will be given to assuring that individuals leaving hospitals are connected to community services upon discharge, and that discharge planning will include community input regarding service recommendations. Person Centered Planning (PCP) will be conducted for all individuals that are hospitalized longer than 60 days, to identify individual goals and all supports necessary to ensure success in community services. During FY 2005, the PCP process will be implemented throughout the system, following training and mentoring provided by a contracted consulting organization. Regions will continue to assure that PCPs are conducted as necessary for the remaining two years of this plan. These activities will continue for all three years of this state plan.
Goal 4:	Improve functioning of youth with SED through comprehensive community- based treatment services
Indicator 4.1:	Percentage of youth with SED for whom there are positive changes in level of functioning
Target 4.1:	Increase percentage of youth with SED who show improvement in level of functioning by 1% per year for FY2005, FY2006 and FY2007
Action Plan:	The DMHDDAD will provide training and technical assistance on the CAFAS instrument and Performance Measurement Evaluation Systems (PERMES) staff will provide technical assistance to regions and providers

on reporting CAFAS data for matching enrollment CAFAS scores with 90 day follow up scores to track improvement in level of functioning after 90 days of service. These activities will continue for all three years of this state plan.

Goal 5:	Families will perceive positive change in their children as a result of services received
Indicator 5.1:	Percentage of families who report positively about outcomes
Target 5.1:	Positive response about outcomes of services will increase by 0.5% per year for FY 2006 and 2007 over the baseline report for FY2005
Action Plan:	The DMHDDAD has identified family satisfaction as a quality improvement area due to low satisfaction scores on the PERMES Family Survey over the past two years. The Quality Improvement staff and C&A MH program staff in the Division are currently conducting a series of family satisfaction workgroup sessions to identify approaches to improve family satisfaction. There are family members on the workgroup as well as providers and regional C&A staff. These activities will continue for all three years of this state plan.

CRITERION 2: Mental Health Systems Data Epidemiology

Current Activities

Georgia's plans for system capacity and service development for youth with serious emotional disturbance and their families needs are based on federal estimates of prevalence for youth ages 9-17 with SED. Prevalence tables are constructed annually for each MHDDAD region based on county population figures for each county in the region. Regional offices and regional planning boards use these tables to determine the number of youth in the region that could be expected to require public child and adolescent mental health services.

Currently, a new child and adolescent "Core Customer" definition is being developed to better identify those who are eligible to receive public sector child and adolescent mental health services. This new definition will incorporate the elements of the federal definition for SED and also sets diagnostic and functional criteria to identify eligibility for brief intervention/early intervention for youth who do not necessarily meet the SED definition.

Data to support planning and to monitor service effectiveness is collected through several processes. The contracted Medicaid ERO collects and reports consumer encounter data that includes information on consumer level of need and response to treatment. This information is currently generated for all Medicaid eligible consumers, which represents approximately half of the youth served in the public mental health system.

System evaluation information continues to be collected through the PERMES system. Both consumer surveys and clinical functional assessment information is utilized in system evaluation.

All child and adolescent mental health consumers are assessed using the Child and Adolescent Functional Assessment Scale (CAFAS) upon enrollment/intake and 90 day follow ups to determine functional improvement.

The statewide information system provides enrollment data for all consumers enrolled in the system. Because the MHIS system uses unique identifiers for each individual enrolled in the system, data can be unduplicated for reporting purposes. This system has several flaws that inhibit the division's ability to capture all the information that is desired for planning and reporting purposes, but the state's participation in the CMHS Data Infrastructure Grant (DIG) is providing support in developing systems that will improve decision- making and service delivery.

Goals, Targets and Action Plans

The goals enumerated for this criterion are long term in nature and will direct the Plan for FY 2005 through FY 2007 unless otherwise stated.

- | | |
|-----------------------|---|
| Goal 1: | Expand access to mental health services for youth with SED |
| Indicator 1.1: | Percentage of youth with SED served in public MHDDAD service system |
| Target 1.1: | Percentage of treated prevalence will increase by 1% each year in FY2005, FY2006 and FY2007 |
| Action Plan: | The DMHDDAD will provide technical assistance to regions and providers on increasing the penetration rates and identifying consumers for mental health treatment services and working collaboratively with other child-serving agencies to identify and serve youth with SED in community mental health programs. These activities will continue for all three years of this state plan. |
| | |
| Goal 2: | Georgia will provide community mental health services for youth with Serious Emotional Disturbances needing publicly funded services |
| Indicator 2.1: | Children and adolescents served in the public mental health system |
| Target 2.1: | Georgia will increase numbers served by 50 youth in FY 2006 and FY 2007 over the baseline reported for FY 2005 |
| Action Plan: | Georgia will continue to provide an array of community services to youth with SED. As funding for child and adolescent mental health services is not anticipated to increase during the reporting period, regions will encourage providers to aggressively pursue Medicaid and SCHIP eligibility for individuals who qualify. The state will improve service entry and linkage functions through the implementation of a statewide call center. Georgia expects to implement the statewide call center during FY 2005. These activities will continue for all three years of this state plan. |

CRITERION 3: Children's Services

Current Activities

One of the activities the DMHDDAD is involved with is transitional planning for youth aging out of the Level of Care (LOC) system. In 2002, a Transition Protocol was developed and put into policy and practice at the state and regional MHDDAD. DFCS, DJJ, Department of Labor/Vocational Rehabilitation, residential service providers and other key stakeholders met for a series of months to develop a protocol to identify youth in the LOC that were turning 17 years old in order to begin systematically planning for their discharge from residential treatment programs back to their own homes and/or communities at age 18. One of the new indicators in this plan will track the number of youth with SED who are referred for transition planning under the protocol.

The continued goal for the DMHDDAD is to serve youth with SED as close to their natural home settings as possible. By providing integrated and community based services, many youth with SED can be served without being placed outside their homes and communities. Regional Coordinators and Regional Services Administrators in each of the seven regions are responsible for partnering with other child-serving agencies to improve service integration and service delivery for youth who have multi-agency involvement and reducing out of home placements for these youth. Reducing out-of-home placements continues to be one of the primary objectives in Georgia.

Additionally, providing services to youth involved with the juvenile justice system is key to keeping youth in their communities and out of detention or further penetration into the juvenile justice system. Through the PERMES project, reporting forms that providers submit to the state include identifiers for youth who are served in the mental health programs who are also involved with the juvenile justice system. One of the goals for the DMHDDAD is to continue to increase the number of youth served who are also involved in juvenile justice systems and to collaborate more effectively with the juvenile justice and court systems on creative approaches to serve youth in the community to avoid out of home placements such as detention, commitments to the state and long term residential placements. The DMHDDAD is well positioned to address complex system issues that affect the DJJ and local mental health systems, as the new Division Director is a former Deputy Commissioner of the Department of Juvenile Justice. The goal is for the two departments to work together on identifying strategies on serving multi- system involved youth and for each agency not to duplicate services or create parallel mental health systems by default. Over representation of ethnic minority youth in the juvenile justice system is a problem that is well known nationwide. The DMHDDAD wants to continue to track ethnic minority youth served in juvenile justice to ensure that this vulnerable population receives access to treatment services through mental health and not just the juvenile justice system.

Improvement in school/work performance is an issue that is being addressed across the country and the DMHDDAD is interested in tracking improvements in functioning for youth with SED for whom there are severe school/work impairments upon enrollment. Upon enrollment/intake

into the service system, the CAFAS is completed on all youth. After 90 days of services, follow up CAFAS instruments are scored and the DMHDDAD plans to track improvement on the school/work subscale on the CAFAS for those youth who are having the most difficulty and show the most severe impairment upon enrollment.

The DMHDDAD is committed to improving Systems of Care for youth with SED and their families. Through the SOC QI Initiative in FY2004, the regions and their key stakeholders were provided with training and technical assistance to develop SOC Action Plans to identify areas that were challenges to the regional SOC's. The DMHDDAD will continue to work with the Regions to reinforce the importance of developing and continuing to expand and improve local Systems of Care through the Action Planning process.

Goals, Targets and Action Plans

The goals enumerated for this criterion are long term in nature and will direct the Plan for FY 2005 through FY 2007 unless otherwise stated.

- | | |
|-----------------------|--|
| Goal 1: | Provide integrated services for youth with SED to enable them to live in their home communities |
| Indicator 1.1: | Youth with SED in Level of Care residential treatment, age 17 who are referred for transition planning |
| Target 1.1: | Increase the number of youth referred for transition planning by 10 for FY 2006 and FY 2007 over the baseline reported in FY 2005 |
| Action Plan: | DMHDDAD staff will collect data on numbers of transition planning referrals from the STAC/LOC staff and work with Regional Office staff on any problematic issues related to implementation of the protocol. The Division's program staff will continue to meet with the regional C&A MH Program Specialists and Adult MH Program Specialists on a regular basis and include Transition protocol and planning as a critical agenda item for planning and tracking. The DMHDDAD staff are involved in the Transition workgroup which meets monthly to develop strategies to serve the transitional population of youth aging out of the children's system with a focus primarily on young adults aging out of the LOC. These activities will continue for all three years of this state plan. |
| Goal 2: | Provide services to youth with SED who are involved in the juvenile justice system |
| Indicator 2.1: | Percentage of all youth with SED who are also involved with the juvenile justice system |
| Target 2.1: | Increase percentage of youth with SED served who are also involved in the juvenile justice system by 1% for FY 2006 and FY 2007 over the baseline data reported in FY 2005 |
| Action Plan: | The DMHDDAD will provide technical assistance to the regions and providers on approaches to serve more youth involved in the juvenile justice system. The new DMHDDAD Director is a former Deputy |

Commissioner of DJJ and plans to focus on collaboration between the two departments to ensure increased services to this population. These activities will continue for all three years of this state plan.

- Goal 2:** Increase percentage of youth with SED served who are also involved in the juvenile justice system by 1% for FY 2006 and FY 2007 over the baseline data reported in FY 2005
- Indicator 2.2:** Percentage of ethnic minority youth with SED who are also involved with the juvenile justice system
- Target 2.2:** Increase services to racial and ethnic minority youth with SED who are involved in the juvenile justice system by 1% over the number served per year for FY2005, FY2006 and FY2007
- Action Plan:** The DMHDDAD will provide technical assistance to the regions and providers on approaches to serve more youth involved in the juvenile justice system. The new DMHDDAD Director is a former Deputy Commissioner of DJJ and plans to focus on collaboration between the two departments to ensure increased services to this population. In addition, the Mental Health Planning and Advisory Council plans to track the racial and ethnic minority population and issues surrounding this group through its Monitoring and Evaluation committee, with assistance from DJJ staff on the Council. These activities will continue for all three years of this state plan.
- Goal 3:** Improve functioning of youth with SED through comprehensive community based treatment services
- Indicator 3.2:** Percentage of youth with SED for whom there are positive changes in their school/work performance
- Target 3.2:** Increase percentage of youth with SED for whom there are positive changes in their school/work performance by 1% in FY2006 and FY2007 over the baseline data reported in FY 2005
- Action Plan:** The PERMES staff will provide technical assistance to the regions and their providers surrounding school/work performance measures and the need to track this area of life for youth with SED. These activities will continue for all three years of this state plan.
- Goal 4:** Improve Systems of Care (SOC) for youth with SED and their families
- Indicator 4.1:** Number of regions that report progress towards goals in SOC Quality Improvement Action Plans
- Target 4.1:** Number of regions that report progress towards goals in SOC Action Plans will increase for FY2006 and FY2007 over the baseline for FY2005
- Action Plan:** The DMHDDAD will require the regions to report quarterly on progress made on SOC Action Plans. This will allow DMHDDAD to address any barriers to implementation identified by the regions.

CRITERION 4: Targeted Services to Rural and Homeless Populations

Current Activities

Access to care is a system indicator valued by the DMHDDAD and the regional offices. Access to care in rural areas poses many challenges and potential barriers to service delivery for consumers and providers. For this reason, the goal related to access to care for consumers in rural areas continues to be tracked through the PERMES project. The Mental Health Planning and Advisory Council has continued to express a further desire to look at access as it relates to ethnic and non-ethnic minority groups. The President's New Freedom Commission on Mental Health: *Achieving the Promise* report has a goal to "Improve access to quality care in rural and geographically remote areas" and the DMHDDAD has set a goal in this section of the plan to report data on increasing services to youth with SED and their families in rural areas of Georgia.

The regions' providers are now required to enter data on numbers served directly into the management information systems (MIS) that is reported directly to the DMHDDAD through PERMES.

As mentioned in Section II, the FY 2005 gap analysis of the mental health service system will help identify unique needs and gaps in services for homeless and for rural consumers. Additionally, the information gleaned from the PERMES data collection process will assist DMHDDAD in determining the scope of the problem with homeless youth and lead to a more informed planning effort.

Goals, Targets and Action Plans

The goals enumerated for this criterion are long term in nature and will direct the Plan for FY 2005 through FY 2007 unless otherwise stated.

- | | |
|-----------------------|--|
| Goal 1: | Increase percentage of mental health services delivered outside a clinic setting for youth living in rural areas. This goal relates to Recommendation 3.2 of <i>Achieving the Promise</i> , to "improve access to quality of care in rural and geographically remote areas". |
| Indicator 1.1: | Percentage of youth with SED enrolled in community services in rural areas receiving Intensive Family Intervention (IFI), Community Support Team (CST), or Community Support Individual (CSI) services |
| Target 1.1: | Increase by 2% each year for FY 2006 and 2007 the number of youth with SED in rural areas receiving services outside a clinic setting over the baseline reported in FY2005. |
| Action Plan: | The DMHDDAD will provide technical assistance to regions and providers on IFI, CST and CSI services and continue to review request for waivers to the Medicaid standards to assist regions and providers with |

plans to address professional staffing shortages in rural areas. These activities will continue for all three years of this state plan.

Goal 2:	Provide services to youth with SED and their families who report being homeless
Indicator 2.1:	Youth with SED and their families who report being homeless upon enrollment in services
Target 2.1:	Increase percentage of youth with SED and their families served who report being homeless by 1% each year over the baseline number reported in FY2005
Action Plan:	The DMHDDAD will track the number of homeless youth with SED and their families through the PERMES reporting process and plan for more outreach to this population. Providers will now be able to collect information and report to DMHDDAD on the consumers living situation upon enrollment. This information will enable DMHDDAD to determine where to concentrate efforts for outreach and development of additional community support services.

CRITERION 5: Management Systems

Current Activities

Georgia's total budget for child and adolescent mental health services is \$66,261,234, of which 72.7% is allocated to community services. Community mental health services for children and adolescents are funded through a combination of state, federal and Medicaid resources. All community services are provided through contracts between the MHDDAD regional offices and independent provider entities. Resources are allocated to the seven MHDDAD regional offices based on historical distribution and funding formulas that include factors for poverty and population.

The Georgia General Assembly appropriates funding for services during its annual session when it passes the state budget. The budget for the DMHDDAD is included as part of the overall budget for the Department of Human Resources. The board of DHR must first accept requests for new appropriations for inclusion in the DHR budget, which is then sent to the governor for consideration for inclusion in his budget proposal. The two bodies of the General Assembly pass budgets that are then brought to a conference committee to finalize the budget for the coming state fiscal year. For the past three years, the state has experienced declining revenues and the governor has requested all state agencies to submit budget requests reflecting a mandated percentage reduction. Most of the reductions taken by MHDDAD have been in administration or in hospital services, maintaining the focus on community-based services. Because of these budget restraints however, there have not been increased appropriations for services even though numbers needing services have increased.

Staffing requirements are established in the service standards for each category of service, and are specified in the Provider Manual that is included as an attachment to each provider contract. Staffing requirements are the same for Medicaid funded and state grant-in-aid funded services. The ERO service utilization monitoring includes review of staffing to assure that both numbers of staff and credentials meet the guidelines.

As discussed in Section II of this document, standards require agencies to plan for staff competency development and training. Some training for provider staff is offered by DMHDDAD through a variety of conferences and training events. DMHDDAD has a budget of \$44,315 available for training initiatives. State and regional staff with subject matter expertise also provide technical assistance. Training of crisis services staff is also described in Section II.

The following tables indicate how the state spent MHBG funds for state FY 2004 and the plans for expenditures for FY 2005. Because Georgia's service contracting is done annually, it is not possible to forecast the expenditures beyond the current fiscal year. New Planned Expenditures tables will be provided with the annual application for FY 2006 and FY 2007.

**FY 2004 FEDERAL MENTAL HEALTH BLOCK GRANT FUNDS
(C&A MENTAL HEALTH SERVICES, CONTRACTED)**

REGION	PROVIDER	CONTRACTED AMOUNT	SERVICES
North	Cobb County CSB	\$196,688	5
	Georgia Mountains CSB	\$610,089	1,2,4,5,6,7
	Haralson County Board of Health	\$ 25,315	1,4,5
	Highland Rivers CSB	\$478,337	1,2,3,4,5,6,7
	Lookout Mountain CSB	\$37,371	1,2,3,4,5,6,7
Metro	Chris Kids, Inc.	\$111,041	6
	Clayton County CSB	\$118,174	1,4,7
	Creative Community Services, Inc.	\$96,112	3,6,7
	DeKalb Community Service Board	\$770,944	1,2,4,5,6,7
	Family Intervention Specialists	\$124,089	1
	Integrated Health Resources	\$78,238	1
	Georgia Community Support and Solutions	\$44,364	1
	GA Parent Support Network	\$274,962	1,2,5
	Inner Harbour, LTD	\$389,824	4
	Regional Reserve	\$39,501	
West Central	McIntosh Trail CSB	\$118,174	1,2,3,4,5,6,7
	Middle Flint CSB	\$129,000	1,2,3,4,5,6,7
	New Horizons CSB	\$542,225	1,2,3,4,5,6,7
	Pathways CSB	\$110,000	1,2,3,4,5,6,7
	Twin Cedars Youth Services	\$72,800	5
	Regional Reserves	\$196,688	5

Central	CSB of Middle Georgia	\$196,687	5
	Phoenix Center CSB	\$160,000	1,4,6,7
East Central	Advantage Behavioral Health	\$315,471	1,2,3,4,5,6,7
	CSB of East Central Georgia	\$12,128	1,2,4,5,6,7
	Ogeechee CSB	\$177,159	1,2,3,4,5,6,7
	Medical College of Georgia	\$196,687	5
Southwest	Albany Area Community Service Board	\$94,500	1,2,3,4,5,6
	Georgia Pines CSB	\$94,500	1,2,3,4,5,6
Southeast	Gateway CSB	\$984,679	1,2,3,4,5,6,7
	Pineland Community Service Board	\$93,708	1,2,3,4,5,6,7
	Satilla CSB	\$96,000	1,2,3,4,5,6,7
Total		\$6,985,455	

SERVICES:

1. Outpatient services (screening to determine appropriateness of state hospital admissions, clinical assessment, individual, group and/or family counseling, medication administration and management).
2. Wraparound services
3. 24- hour emergency care services
4. Day treatment services
5. Crisis services (including mobile crisis, in-home, in-clinic, and crisis residential)
6. Residential services
7. Respite services

**FY 2005 FEDERAL MENTAL HEALTH BLOCK GRANT FUNDS
(C&A MENTAL HEALTH SERVICES, PLANNED)**

REGION	PROVIDER	PLANNED AMOUNT	SERVICES
North	Cobb County CSB	\$196,688	1,2,3,4,5,6,7
	Georgia Mountains CSB	\$610,089	1,2,3,4,5,7
	Haralson County Board of Health	\$25,315	1,3
	Highland Rivers CSB	\$478,337	1,2,3,4,5,6,7
	Lookout Mountain CSB	\$37,371	1,2,3,4,5,6,7
Metro	Chris Kids	\$111,041	2,6
	Clayton County CSB	\$118,174	1,2,3
	Creative Community Services	\$96,112	6
	DeKalb CSB	\$770,944	1,2,3,4,5,6
	Family Intervention Specialists	\$125,360	5
	Georgia Community Support and Solutions	\$44,364	1
	GA Parent Support Network	\$274,962	1,2,3
	Inner Harbour, LTD	\$389,824	4
	Integrated Health Resources	\$78,238	3
	The Odyssey Family Counseling Center	\$35,000	1,5
	Regional Reserve	\$3,230	
West Central	McIntosh Trail CSB	\$118,174	1,2,3,4,5,6,7
	Middle Flint CSB	\$129,000	1,2,3,4,5,6,7
	New Horizons CSB	\$542,225	1,2,3,4,5,6,7

	Pathways CSB	\$110,000	1,2,3,4,5,6,7
	Regional Reserves	\$269,488	
Central	CSB of Middle Georgia	\$196,687	3,6
	Phoenix Center CSB	\$160,000	1,4,6,7
East Central	Advantage Behavioral Health	\$315,471	1,2,3,4,5,6,7
	CSB of East Central Georgia	\$12,128	1,2,4,5,6,7
	Ogeechee CSB	\$177,159	1,2,3,4,5,6,7
	MCG Health	\$196,687	3
Southwest	Albany Area CSB	\$94,500	4
	Georgia Pines CSB	\$94,500	4
Southeast	Gateway CSB	\$984,679	1,2,3,4,5,6,7
	Pineland CSB	\$93,708	1,2,3,4,5,6,7
	Satilla CSB	\$96,000	1,2,3,4,5,6,7
Total		6,985,455	

SERVICES:

1. Outpatient services (screening to determine appropriateness of state hospital admissions, clinical assessment, individual, group and/or family counseling, medication administration and management).
2. Wraparound services
3. 24- hour emergency care services
4. Day treatment services
5. Crisis services (including mobile crisis, in-home, in-clinic, and crisis residential)
6. Residential services
7. Respite services

Goals, Targets and Action Plans

The goals enumerated for this criterion are long term in nature and will direct the Plan for FY 2005 through FY 2007 unless otherwise stated.

Goal 1:	A majority of mental health services for youth with SED will be delivered in community settings rather than in psychiatric hospitals
Indicator 1.1:	Total budgeted funds for child and adolescent mental health community services as a percentage of total child and adolescent mental health budget
Target 1.1:	Percentage of funding for community services will continue to be the majority of the child and adolescent mental health services budget
Action Plan:	The DMHDDAD continues to focus on building system capacity in the community-based programs versus the state hospital units. The regions are exploring service expansions with their providers in order to expand community services and decrease utilization of hospital units. Funds for services will continue to be allocated to regional offices, which will contract for and monitor services. State and regional office staff will provide technical assistance to community service providers and to hospital staff regarding continuity of care and appropriate service planning to encourage retention in community services and to facilitate the earliest possible return to community services following any necessary hospitalizations. These activities will continue for all three years of this state plan.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 1
Core Performance Indicator**

Goal 1:	Evidenced-Based Practice services will be available to all youth with SED
Target:	Increase number of youth with SED receiving EBP services by 10 in FY 2006 and FY 2007 over the baseline data reported for FY2005.
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Comprehensive Community Based Mental Health Service System
Brief Name:	Evidenced-Based Practice Services
Indicator 1.1	Youth with SED receiving Therapeutic Foster Care services
Measure:	Number of youth receiving Therapeutic Foster Care services.
Source(s) of Information:	State-wide information system (MIS)
Significance:	The DMHDDAD has committed to implementation of evidenced-based practices for all people served in the system. Therapeutic foster care is the only evidenced-based practice for children and adolescents available through DMHDDAD at this time. When out of home treatment is needed for youth with SED, therapeutic foster care services enable the youth to remain in their home communities and allow opportunities for the family or foster family to be involved in treatment.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR**

Criterion 1

Core Performance Indicator

Goal 1:	Evidenced-based practice services will be available to all youth with SED
Target:	Evidenced-based practice services will be available in all seven DMHDDAD regions in Georgia.
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Comprehensive Community Based Mental Health Service System
Brief Name:	Evidenced-Based Practice Services
Indicator 1.2:	Percentage of DMHDDAD regions that have Therapeutic Foster Care Services available to youth with SED and their families
Measure:	<u>Numerator:</u> Number of DMHDDAD regions that have Therapeutic Foster Care services <u>Denominator:</u> Total number of DMHDDAD regions
Source(s) of Information:	Statewide information system (MIS)
Significance:	The DMHDDAD has committed to implementation of evidenced-based practices for all people served in the system. When out of home treatment is needed for youth with SED, therapeutic foster care services enable the youth to remain in their home communities and allow opportunities for the family or foster family to be involved in treatment.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 1
State Specific Performance Indicator

Goal 2:	Best Practice/Promising practice services will be available to all youth with SED
Target:	Increase percentage of youth with SED receiving best practice/promising practices services by 1% in FY 2006 and FY 2007 over the baseline data reported for FY 2005
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Comprehensive Community Based Mental Health Service System
Brief Name:	Best Practice/Promising Practice services
Indicator 2.1:	Percentage of youth receiving best practice/promising services
Measure:	<p><u>Numerator:</u> Unduplicated number of youth with SED enrolled in intensive family intervention services, community support services, family support services and respite care</p> <p><u>Denominator:</u> Total number of youth with SED enrolled in publicly supported community mental health services during the fiscal year</p>
Source(s) of Information:	State-wide information system (MIS)
Significance:	The DMHDDAD has committed to implementation of best practices/promising practices for all people served in the system. By providing these youth and family-based and centered services, youth with SED will be able to avoid hospitalization and other out of home placements.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 1
Core Performance Indicator

Goal 3:	Decrease the number of consumers being readmitted to state hospitals within 30 and 180 days of being discharged
Target:	Reduce 30-day readmission rates by 0 .5% each year for FY2005, 2006 and 2007 Reduce 180-day readmission rates by 0.5% each year for FY2006 and 2007 over the baseline established for FY2005
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Comprehensive Community Based Mental Health System
Brief Name:	Re-admissions
Indicator 3.1:	Percentage of youth readmitted to state hospital inpatient care within 30 days of discharge
Indicator 3.2:	Percentage of youth readmitted to state hospital inpatient care within 180 days of discharge
Measure:	<p><u>Numerator:</u> Of the total number of youth discharged during the reporting period, percentage who were readmitted to acute care state operated inpatient unit within 30/180 days</p> <p><u>Denominator:</u> Total number of discharges from acute care state operated inpatient units that occurred during the reporting period.</p>
Source(s) of Information:	Hospital information – (BHIS)
Significance:	High numbers of youth readmitted to state psychiatric inpatient care within 30/180 days of being discharged may reflect treatment failure, premature discharges or lack of community follow-up, which are inverse aspects of good outcomes and high quality/appropriate care. A community-based system of care is expected to impact utilization of hospital beds. When appropriate services are provided in community settings after hospital discharge, it is expected that re-admissions may be reduced.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 1
State Specific Performance Indicator**

Goal 4:	Improve functioning of youth with SED through comprehensive community based treatment services
Target:	Increase percentage of youth with SED who show improvement in level of functioning by 1% per year for FY2005, FY2006 and FY2007
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Comprehensive Community Based Mental Health Service System
Brief Name:	Improved Functioning
Indicator 4.1:	Percentage of youth with SED for whom there are positive changes in level of functioning
Measure:	<p><u>Numerator:</u> Number of youth with SED who have a completed enrollment CAFAS and follow up CAFAS who show improvement in level of functioning.</p> <p><u>Denominator:</u> Total number of youth with SED who have a completed enrollment and follow up CAFAS</p>
Source(s) of Information:	PERMES data
Significance:	The DMHDDAD considers the desired outcome of services to be positive changes in level of functioning. The PERMES (Performance Measurement and Evaluation System) project uses the CAFAS assessment tool to measure functional improvement and outcomes. Youth who have a 50 or higher CAFAS score are considered to have SED. CAFAS is scored at intake/enrollment and follow up CAFAS is scored after 90 days of service. Only matched pairs of CAFAS intake and 90 day follow up scores are used to measure this indicator.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 1
Core Performance Indicator

Goal 5:	Families will perceive positive change in their children as a result of services received
Target:	Positive response about outcomes of services will increase by 0. 5% per year for FY 2006 and 2007 over the baseline report for FY2005
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Comprehensive Community Based Mental Health Service System
Brief Name:	Perception of Care
Indicator 5.1:	Percentage of families who report positively about outcomes
Measure:	<p><u>Numerator:</u> Number of positive responses reported in the outcome domain on the family satisfaction survey.</p> <p><u>Denominator:</u> Total number of responses reported in the outcome domain on the family satisfaction survey</p>
Sources (s) of Information:	PERMES Family Satisfaction Survey (MHSIP YSS/Family Survey)
Significance:	The indicator captures the family's perception of the effectiveness of services and the positive outcomes that resulted from treatment and support received by the youth and family. Positive response for this measure is based on the responses to several survey questions related to service effectiveness. The DMHDDAD will focus on family satisfaction during the fiscal year through a Quality Improvement process that will include participation from family members, providers, regional and state office staff.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 2
State Specific Performance Indicator**

Goal 1:	Expand access to mental health services for youth with SED
Target:	Percentage of treated prevalence will increase by 1% each year over baseline in FY 2005, FY2006 and FY2007
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Mental Health System Data Epidemiology
Brief Name:	Prevalence and Treated Prevalence of SED
Indicator 1.1:	Percentage of youth with SED served in public MHDDAD service system
Measure:	<u>Numerator:</u> Total number of youth ages 9-17 with SED served by the public sector in the fiscal year <u>Denominator:</u> Estimated youth population ages 9-17 with SED
Source(s) of Information:	State-wide information system, Federal estimate of the SED population, and the Georgia County Guide
Significance:	The number served by the public MHDDAD system reflects only those enrolled in services ages 9-17, and does not include individuals who receive services from other agencies. As funding for services is not expected to be increased in the coming three years, targets for this indicator are minimal. Note: The method of estimated prevalence for FY2003 was based on 7% of the estimated population for the 9-17 age group and the FY2004 estimated prevalence is based on 8% prevalence and utilizing data in the 2002 Uniform Reporting System Table (URS Table). Therefore, the FY2003 Actual data on this indicator cannot be compared to the FY2004 data. FY2004 becomes the new baseline for this indicator.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 2
Core Performance Indicator

Goal 2:	Georgia will provide community mental health services for youth with Serious Emotional Disturbances needing publicly funded services
Target:	Georgia will increase numbers served by 50 youth in FY 2006 and FY 2007 over the baseline reported for FY 2005
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Mental Health System Data Epidemiology
Brief Name:	Increased access to services
Indicator 2.1:	Children and adolescents served in the public mental health system
Measure:	Number of children and adolescents under age 18 served
Source(s) of Information:	State wide information system
Significance:	The number served by the public MHDDAD system reflects only those enrolled in services, and does not include individuals who receive services from other agencies or those wanting or needing services, but not enrolled. It is not anticipated that new resources will be available in the coming three years, so the targets for increasing numbers to be served are set very low in recognition of static funding.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 3
State Specific Performance Indicator

Goal 1:	Provide integrated services for youth with SED to enable them to live in their home communities
Target:	Increase the number of youth referred for transition planning by 10 for FY 2006 and FY 2007 over the baseline reported in FY 2005
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Children's Services
Brief Name:	Transition Planning
Indicator 1.1:	Youth with SED in Level of Care residential treatment, age 17 who are referred for transition planning
Measure:	Number of youth with SED in LOC residential treatment, age 17 who are referred for transition planning
<u>Source(s) of Information:</u>	Level of Care Data
Significance:	Through multi-agency participation and collaboration among child-serving agencies, residential providers and key stakeholders, the MATCH-Transition Protocol was developed and put into DMHDDAD policy in late 2002. Youth who are in residential placements through the former MATCH program (now referred to as Level of Care) are now identified for Transition planning at age 17 to allow adequate time and planning prior to the youth aging out of the children's service system. The protocol assists residential providers, regional MHDDAD offices, child welfare, juvenile justice and all other involved parties to engage in the transition planning process for this group of young adults in residential care who are being reintegrated back in to the community.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 3**

State Specific Performance Indicator

Goal 2:	Provide services to youth with SED who are involved in the juvenile justice system
Target:	Increase percentage of youth with SED served who are also involved in the juvenile justice system by 1% for FY 2006 and FY 2007 over the baseline data reported in FY 2005
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Children's Services
Brief Name:	Juvenile Justice
Indicator 2.1:	Percentage of all youth with SED who are also involved with the juvenile justice system
Measure:	<u>Numerator:</u> Total number of with SED served who are also involved with the juvenile justice system <u>Denominator:</u> Total number of youth with SED served
Source(s) of Information:	PERMES data CAFAS
Significance:	In FY2002, the providers reported CAFAS scores for all youth enrolled in services. Through PERMES, the reporting form was revised to include a field to report juvenile justice referrals. The goal for this indicator has been changed to include youth who are involved in the juvenile justice system. The original goal focused on youth in detention or on probation only.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 3
State Specific Performance Indicator**

Goal 2:	Provide services for youth with SED who are in the juvenile justice system
Target:	Increase services to racial and ethnic minority youth with SED who are involved in the juvenile justice system by 1% for FY2005, FY2006 and FY2007 over the baseline reported for FY2004
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Children's Services
Brief Name:	Juvenile Justice- racial and ethnic minority
Indicator 2.2:	Percentage of racial and ethnic minority youth with SED who are also involved with the juvenile justice system
Measure:	<p><u>Numerator:</u> Total number of racial and ethnic minority youth with SED served who are also involved with the juvenile justice system</p> <p><u>Denominator:</u> Total number of racial and ethnic minority youth with SED served</p>
Source(s) of Information:	PERMES data CAFAS
Significance:	In FY2002, the providers reported CAFAS scores for all youth enrolled in services. Through the PERMES, the reporting form was revised to include a field to report juvenile justice referrals. The goal for this indicator was changed to include ethnic minority youth who are involved in the juvenile justice system due to over-representation of ethnic minority youth in the juvenile justice system. The original goal focused on ethnic minority youth in detention or on probation only. Note: FY2003 Actual data was measured by involvement over the past three months. The FY2004 Actual data was measured by juvenile justice involvement over the past year, as required by the Data Infrastructure Grant (DIG) reporting requirements. Therefore, FY 2004 becomes the baseline year for this indicator.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 3
State Specific Performance Indicator**

Goal 3:	Improve functioning of youth with SED through comprehensive community based treatment services
Target:	Increase percentage of youth with SED for whom there are positive changes in their school/work performance by 1% in FY2006 and FY2007 over the baseline data reported in FY 2005
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Children's Services
Brief Name:	Improved functioning-school/work performance
Indicator 3.2:	Percentage of youth with SED for whom there are positive changes in their school/work performance
Measure:	<p><u>Numerator:</u> Total number of youth with SED with severe school/work impairment upon enrollment whose level of impairment in school/work declines to moderate or less upon follow-up CAFAS after 90 days of service</p> <p><u>Denominator:</u> Total number of youth with severe school/work impairment on the CAFAS school/work subscale upon enrollment</p>
Source(s) of Information:	PERMES
Significance:	Improvement in school/work performance is being tracked through the PERMES project. This indicator includes work performance as well as school performance and will be captured on the school/work subscale of the CAFAS through PERMES data. This indicator is focused on youth who have severe impairment in school/work functioning upon enrollment and tracking positive changes in school/work behavior. Lack of severe impairment means youth are in school or have a job and are meeting the minimum requirements for behavior in the classroom or on the job.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 3
State Specific Administrative Indicator

Goal 4:	Improve Systems of Care (SOC) for youth with SED and their families
Target:	Number of regions that report progress towards goals in SOC Quality Improvement Action Plans will increase for FY2006 and FY2007 over the baseline of FY2005.
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Children's Services
Brief Name:	System of Care Improvements
Indicator 4.1:	Regions that report progress towards goals in SOC Quality Improvement Action Plans
Measure:	Number of regions that report progress towards goals in SOC Quality Improvement Action Plans
<u>Source(s) of Information:</u>	Regional MHDDAD reports
Significance:	The DMHDDAD is committed to improving Systems of Care for youth with SED and their families. Through the SOC QI Initiative in FY2004, the regions and their key stakeholders were provided with training and technical assistance to develop SOC Action Plans to identify areas that were challenges to the regional SOC's. The DMHDDAD will continue to work with the Regions to reinforce the importance of developing and continuing to expand and improve local Systems of Care through the Action Planning process.

**STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 4
State Specific Performance Indicator**

Goal 1:	Increase percentage of mental health services delivered outside a clinic setting for youth living in rural areas
Target:	Increase by 2% each year for FY 2006 and 2007 the number of youth with SED in rural areas receiving services outside a clinic setting over the baseline reported in FY2005.
Population:	Children and adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Targeted Services to Homeless Populations/Targeted Services to Rural Populations
Brief Name:	Rural Population Services
Indicator 1.1:	Percentage of youth with SED enrolled in community services in rural areas receiving Intensive Family Intervention (IFI), Community Support Team (CST), or Community Support Individual (CSI) services
Measure:	<p><u>Numerator:</u> Number of rural area youth with SED enrolled in IFI, CST and/or CSI.</p> <p><u>Denominator:</u> Number of enrolled youth with SED who live in rural areas</p>
Source(s) of Information:	Statewide Information System
Significance:	Youth with SED living in rural counties of the state have difficulties accessing services because of distance to service locations and lack of transportation. With the rehab option, there is greater emphasis on providing services outside the traditional clinic setting to youth and there families. Rural designation relates to counties that lie completely outside a Metropolitan Statistical Area (MSA). Georgia has 159 counties, with 23% being included in MSA's and 77% designated as rural. Data reported for FY 2005 will provide a baseline for this indicator.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 4
State Specific Performance Indicator

Goal 2:	Provide services to youth with SED and their families who report being homeless
Target:	Increase percentage of youth with SED and their families served who report being homeless by 1% each year over the baseline number reported in FY2005
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Targeted Services to Homeless Populations/Targeted Services to Rural Populations
Brief Name:	Homeless Services
Indicator 2.1:	Youth with SED and their families who report being homeless upon enrollment in services
Measure:	<u>Numerator:</u> Total number of youth and their families who report being homeless upon enrollment in services. <u>Denominator:</u> Total number of youth with SED and their families served
Source(s) of Information:	Statewide information system
Significance:	Until this fiscal year, there has not been a method to collect data on the numbers of homeless youth served and their families. In previous fiscal years DMHDDAD attempted to collect this data through the regional annual plan process. Data provided by the regions and their providers was not adequate to provide baseline information. Through the PERMES reporting process, providers will now be able to collect information on the consumers living situation upon enrollment.

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR
Criterion 5
State Specific Performance Indicator

Goal 1:	A majority of mental health services for youth with SED will be delivered in community settings rather than in psychiatric hospitals
Target:	Percentage of funding for community services will continue to be the majority of the child and adolescent mental health services budget.
Population:	Children and Adolescents diagnosed with Serious Emotional Disturbance (SED)
Criterion:	Management Systems
Brief Name:	Community service funding
Indicator 1.1:	Total budgeted funds for child and adolescent mental health community services as a percentage of total child and adolescent mental health budget
Measure:	<p><u>Numerator:</u> Total child and adolescent mental health community budget</p> <p><u>Denominator:</u> Total child and adolescent mental health budget</p>
Source(s) of Information:	State budget reports
Significance:	Georgia is continuing to expand community based public mental health services and reduce the reliance on inpatient psychiatric hospital services. Georgia has reduced child and adolescent inpatient bed capacity for the past several years. As total funding for services is not expected to increase during the coming three-year period, maintaining community-based services funding for youth with SED is the target for this indicator.

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Evidenced-Based Practice Services

Population: Children and Adolescents diagnosed with SED

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY2006 Target	FY2007 Target
Indicator: Youth with SED receiving TFC services	Number Served	Number Served	Number Served	Number Served	Number Served
Measure: Number of youth receiving TFC services	N/A	N/A	Baseline	+10	+10

Name of Performance Indicator: Evidenced-Based Practice Services

Population: Children and Adolescents diagnosed with SED

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of DMHDDAD regions that have TFC services	N/A	N/A	Baseline	100%	100%
Numerator: Number of DMHDDAD regions contracting for TFC	N/A	N/A	Baseline	7	7
Denominator: Total number of DMHDDAD regions	N/A	N/A	7	7	7

Name of Performance Indicator: Best Practice/Promising Practice Services

Population: Children and Adolescents diagnosed with SED

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of youth receiving best practice/ promising practice services	N/A	N/A	Baseline	+1%	+1%
Numerator: Unduplicated number of youth with SED enrolled in IFI, community support services, family support services & respite care	N/A	N/A	Baseline		
Denominator: Total number of youth with SED enrolled in publicly supported community mental health services during the fiscal year	N/A	N/A	Baseline		

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Re-admissions

Population: Children and Adolescents diagnosed with SED

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of youth readmitted to state hospital inpatient care within 30 days of discharge	N/A	N/A	Baseline	- 0. 5%	- 0. 5%
Numerator: Total number of youth discharged during the reporting period who were readmitted to acute care state operated inpatient unit within 30 days	N/A	N/A	Baseline		
Denominator: Total number of discharges from acute care state operated inpatient units that occurred during the reporting period	N/A	N/A	Baseline		

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of youth readmitted to state hospital inpatient care within 180 days of discharge	N/A	N/A	Baseline	- 0. 5%	- 0. 5%
Numerator: Total number of youth discharged during the reporting period who were readmitted to acute care state operated inpatient unit within 180 days	N/A	N/A	Baseline		
Denominator: Total number of discharges from acute care state operated inpatient units that occurred during the reporting period	N/A	N/A	Baseline		

Name of Performance Indicator: Improved Functioning

Population: Children and Adolescents diagnosed with SED

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY2003	FY2004 Actual	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of youth with SED for whom there are positive changes in level of functioning	Baseline 56.3%	60.6%	57.4%	58%	58.6%
Numerator: Number of youth with SED who have a completed enrollment CAFAS and follow-up CAFAS who show improvement in level of functioning	2,315	6,856			
Denominator: Total number of youth with SED who have a completed enrollment and follow-up CAFAS	4,115	11,309			

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Perception of Care

Population: Children and Adolescents diagnosed with SED

Criterion: Comprehensive Community Based Mental Health Service System

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of families who report positively about outcomes	N/A	N/A	Baseline	0. 5%	0. 5%
Numerator: Number of positive responses reported in the outcome domain on the family satisfaction survey	N/A	N/A	Baseline		
Denominator: Total number of responses reported in the outcome domain on the family satisfaction survey	N/A	N/A	Baseline		

Name of Performance Indicator: Prevalence and Treated Prevalence of SED

Population: Children and Adolescents diagnosed with SED

Criterion: Mental Health System Data Epidemiology

Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of youth with SED served in public MHDDAD service system	35.1%	Baseline 33.0%	33.3%	33.6%	34.0%
Numerator: Total number of youth ages 9-17 with SED served by the public sector in the fiscal year	29,096	30,236	30,538	30,840	31,143
Denominator: Estimated C&A population ages 9-17 with SED	82,756	91,562	91,562	91,562	91,562

*Note: FY03 Actual cannot be compared to FY04 Actual because the estimated prevalence methodology utilized has been changed from 7% to 8% of the total estimated child and adolescent population. In addition, the estimated population for FY04 is based on the URS Table from 2002, which is more accurate than the population used in FY2003.

Name of Performance Indicator: Increased access to services

Population: Children and Adolescents diagnosed with SED

Criterion: Mental Health System Data Epidemiology

Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Children adolescents served in the public mental health system	Number served	Number served	Number served	Number served	Number served
Measure: Number of children and adolescents under age 18 served in the fiscal year	N/A	N/A	Baseline	+50	+50

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Transition Planning

Population: Children and Adolescents diagnosed with SED

Criterion: Children's Services

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Youth with SED referred for transition planning	N/A	N/A	Baseline	Number referred	Number referred
Measure: Number of youth referred for transition planning	N/A	N/A	Baseline	+10	+10

Name of Performance Indicator: Juvenile Justice

Population: Children and Adolescents diagnosed with SED

Criterion: Children's Services

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of all youth with SED served who are also involved with the juvenile justice system	N/A	N/A	Baseline	+1%	+1%
Numerator: Total number of all youth with SED served who are also involved with the juvenile justice system	N/A	N/A	Baseline		
Denominator: Total number youth with SED served	N/A	N/A	Baseline		

Name of Performance Indicator: Juvenile Justice- Racial & Ethnic minority

Population: Children and Adolescents diagnosed with SED

Criterion: Children's Services

Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of racial and ethnic minority youth with SED served who are also involved with the juvenile justice system	8.6%	Baseline 14.69%	14.8%	15%	15.1%
Numerator: Total number of racial and ethnic minority youth with SED served who are also involved with the juvenile justice system	739	2074	2095	2116	2137
Denominator: Total number of ethnic minority youth with SED served that a CAFAS was completed for	8,555	14,184	14,184	14,184	14,184

Note: FY2003 Actual data was measured by juvenile justice involvement over the past 3 months. The FY 2004 Actual data was measured by juvenile justice involvement over the past year, as required in the Data Infrastructure Grant (DIG) reporting. Therefore, FY 2004 becomes the baseline year for this indicator.

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Improved functioning-school/work performance

Population: Children and Adolescents diagnosed with SED

Criterion: Children's Services

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of youth with SED for whom there are positive changes in their school/work performance	N/A	N/A	Baseline	+1%	+1%
Numerator: Total number of youth with SED with severe school/work impairment upon enrollment whose level of impairment in school/work declines to moderate or less upon follow-up CAFAS after 90 days of service	N/A	N/A	Baseline		
Denominator: Total number of consumers with severe school/work impairment of the CAFAS school/work subscale upon enrollment	N/A	N/A	Baseline		

Name of Performance Indicator: Systems of Care Improvements

Population: Children and Adolescents diagnosed with SED

Criterion: Children's Services

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Regions that report progress towards goals in SOC QI Action Plans	N/A	N/A	Regions reporting	Regions reporting	Regions reporting
Measure: Number of regions that report progress towards goals in SOC QI Action Plans	N/A	N/A	Baseline	3	7

Name of Performance Indicator: Rural Population Services-Best practices

Population: Children and Adolescents diagnosed with SED

Criterion: Targeted Services to Homeless Populations/Targeted Services to Rural Populations

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Percentage of youth with SED enrolled in community services in rural areas receiving IFI, CST and/or CSI services	N/A	N/A	Baseline	+2%	+2%
Numerator: Number of rural area youth with SED enrolled in IFI, CST and/or CSI services	N/A/	N/A	Baseline		
Denominator: Number of enrolled youth with SED who live in rural areas	N/A	N/A	Baseline		

FY 2005-2007 Performance Indicator Tables

Name of Performance Indicator: Rural Population Services-Homeless Services

Population: Children and Adolescents diagnosed with SED

Criterion: Targeted Services to Homeless Populations/Targeted Services to Rural Populations

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Youth with SED and their families who report being homeless upon enrollment in services	N/A	N/A	Baseline	+1%	+1%
Numerator: Total number of youth and their families who report being homeless upon enrollment in services	N/A	N/A	Baseline		
Denominator: Total number of youth with SED and their families served	N/A	N/A	Baseline		

Name of Performance Indicator: Community Service funding

Population: Children and Adolescents diagnosed with SED

Criterion: Management System

Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Indicator: Total budgeted funds for C&A mental health community services as a percentage of total C&A mental health budget	N/A	N/A	Baseline	Maintain	Maintain
Numerator: Total C&A mental health community budget	N/A	N/A	Baseline		
Denominator: Total C&A mental health budget	N/A	N/A	Baseline		